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ABSTRACT

An Adolescent Study Group was established by the Michigan Department of Public Health/Center for Substance Abuse Services (MCPH/CSAS) to examine the current delivery system of substance abuse treatment services for adolescents. The primary focus was on treatment services for alcohol, tobacco and other drug (ATOD) problems among adolescents in Michigan. The four charges of the group were to: (1) review CSAS current concept papers and other literature and develop a final position paper; (2) recommend how CSAS can assure that adolescents have access to and receive quality treatment services; (3) review current adolescent residential capacity in Michigan and make recommendations for improvement; and (4) provide input to CSAS regarding licensing requirements for adolescent treatment services. Subcommittees made 33 recommendations for improvement of service delivery. Some of the highlighted findings were: special attention to the treatment needs of homeless, runaway and school dropout adolescents is needed; the adult addiction model does not apply to most adolescents and should not be used in a clinical setting; and, adolescents indicated therapy groups should not be a mix of adolescents and adults. A glossary and extensive appendices are also included. Contains 43 references. (JBJ)

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Toward Family Group In Treatment Services For Adolescents

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Submitted *by* Adolescent Study Group

to the CENTER *for* SUBSTANCE ABUSE SERVICES

Michigan Department *of* Public Health

Toward Excellence

In Treatment Services For Adolescents

fall 1993

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Executive Summary

The Michigan Department of Public Health/Center for Substance Abuse Services (MDPH/CSAS) established an Adolescent Study Group in the spring of 1992 to examine the current delivery system of substance abuse treatment services for adolescents. A 32-member study group was selected from a variety of organizations serving adolescents.

Between May and December 1992, eighteen full group and subcommittee meetings were held to focus on key issues. The primary focus of the Adolescent Study Group was on treatment services for alcohol, tobacco and other drug (ATOD) problems among adolescents in Michigan. The four major charges of the study group were to: (1) review CSAS current concept papers and other literature on adolescent treatment services and develop a final position paper; (2) recommend how CSAS can assure that adolescents have access to and receive quality treatment services; (3) review current adolescent residential treatment capacity in Michigan and make recommendations for improvements in services; and (4) provide input to CSAS regarding licensing requirements for adolescent treatment services.

To facilitate discussion and review of materials, the study group approached the task through subcommittees on Access and Quality Assurance. The Access Subcommittee focused on: (1) financing to improve access to treatment services and (2) reviewing current capacity in the state. The Access Subcommittee also studied financial barriers to treatment, assessment and treatment models, comprehensive assessment, continuum of care and ancillary services.

The Quality Assurance Subcommittee focused on: (1) reviewing current guidelines issued by the federal government, MDPH/CSAS and those of other states on adolescent treatment services and (2) providing input regarding licensing, credentialing and contract requirements for providers of adolescent treatment services programming. The Quality Assurance Subcommittee addressed the basic need for special programming for adolescents, gender specific considerations and family involvement in the treatment process. Discussion and surveys also focused on the emotional and physical developmental stages of the adolescent that are a major consideration in the appropriate treatment of an adolescent's substance abuse problem. The resulting position paper provides detailed information, by subcommittee, on their findings and recommendations for action.

The recommendations are directed at improving the quality of treatment services for adolescents and their families in Michigan and reducing access barriers to existing services. The following recommendations are designed as an action strategy for the Center for Substance Abuse Services during the coming years.

Recommendations

ACCESS SUBCOMMITTEE

[redacted]

A plan should be developed by each regional coordinating agency for the provision of adolescent substance abuse treatment services.

[redacted]

Every adolescent and his/her family should have access to a screening for substance abuse services.

[redacted]

Based on the screening and/or assessment, adolescents should have access to comprehensive treatment services regardless of ability to pay.

[redacted]

Each school should have a teacher, counselor or other professional identified and trained to screen and refer youth who exhibit high risk behaviors (i.e., truancy, juvenile delinquency) that may be linked to substance abuse.

[redacted]

There should be regional outreach programs to make adolescents and their families aware of services.

[redacted]

State/federal dollars should be allocated based on adolescent treatment service plans that demonstrate a collaborative working relationship among human services agencies, courts and schools.

[redacted]

Medicaid reimbursement should be made available for all levels of treatment services based on a comprehensive assessment.

[redacted]

An ad hoc committee consisting of officials from service providers, the insurance commission and health insurance companies should be established to address reimbursement of substance abuse services for adolescents.

[redacted]

Title XX funding for substance abuse services should be restored to assist in payment for non-Medicaid eligible children.

[redacted]

Diagnostic criteria, screening and assessment instruments used should be based on adolescent models of chemical dependency.

[redacted]

Treatment services should be community-based to the extent possible, including the provision of "in-home" and "family centered" care whenever possible.

[redacted]

Treatment services must be appropriate for age, developmental level, ethnicity, race and geography.

[redacted]

A state level ad hoc committee consisting of officials from MDPH/CSAS, probate courts, DSS and provider(s) should be established to address legal and other issues specific to delivery of services to adolescents.

[redacted]

Treatment providers should assure that case management services are provided to adolescents.

QUALITY ASSURANCE SUBCOMMITTEE

[redacted]

The comprehensive adolescent treatment model recommended by the Quality Assurance Subcommittee should be adopted statewide and regionally.

[redacted]

Adolescents identified with sexually transmitted diseases should be offered HIV/AIDS testing.

[redacted]

Adolescent treatment programs should adopt abstinence from alcohol, tobacco and other drugs as a treatment goal.

Recommendation #18

Innovative program models should be developed for adolescent care that build on the recommended treatment components.

Recommendation #19

All future substance abuse materials written by MDPH/CSAS used in adolescent substance abuse treatment, including the "Know Your Rights" brochure and treatment consent forms, should be written so that adolescents can easily comprehend their content.

Recommendation #20

The Center for Substance Abuse Services should develop a video that outlines and explains the rights of an adolescent in substance abuse treatment.

Recommendation #21

Adolescent treatment programs should be family centered. Because the family is recognized as a source of power to produce and sustain change, concerted efforts should be made to get involvement of family members in the treatment of adolescents.

Recommendation #22

All third-party payors should reimburse for related family treatment and reimbursement rates for these services should be adequate to cover costs.

Recommendation #23

Adolescent treatment programs should be gender sensitive and address the special needs of homosexual adolescents.

Recommendation #24

MDPH/CSAS should work with the Department of Education to implement the Michigan Student Assistance Program standards.

Recommendation #25

Peers should be involved, as appropriate, in treatment of adolescent substance abusers.

Recommendation #26

Adolescent substance abuse treatment programs should assure that clients receive comprehensive aftercare.

Recommendation #27

Aftercare programs should be provided in schools for returning adolescents to reduce relapse.

Recommendation #28

The court system should consider sending an adolescent to substance abuse treatment prior to placement in a correctional facility. All staff in residential programs serving juvenile offenders should receive training in early identification of possible substance abuse problems and make appropriate referrals for assessments.

Recommendation #29

All licensed substance abuse treatment programs should have a comprehensive Drug-Free Workplace program in place.

Recommendation #30

All substance abuse treatment programs serving adolescents should be tobacco free and should coordinate treatment services with a tobacco cessation program such as the American Lung Association's "Tobacco-Free Teens" program (See Appendix F).

Recommendation #31

Adolescent specific and associated licensing rules as shown in Appendix G should be adopted.

Recommendation #32

Agencies that provide adolescent substance abuse services should employ one full-time clinical staff person possessing a specialty certification for (a) every 40 outpatient clients, (b) every 6 residential clients, and (c) every 12 clients in intensive outpatient treatment.

Recommendation #33

An adolescent addiction specialist certification should be established to recognize professionals who possess degrees or graduate certificates from accredited universities or colleges with core courses that have been identified as necessary in an adolescent substance abuse treatment component.

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Introduction & Study Group Process

Adolescents are a priority target population with the Michigan Department of Public Health Center for Substance Abuse Services (MDPH/CSAS). One of the goals of MDPH/CSAS is to make substance abuse treatment services accessible for underserved populations, including adolescents. CSAS began to address this issue in 1983 when a concept paper was developed on the status of alcohol and other drug use among adolescents. In 1989 the plan was reviewed and updated in a staff briefing paper.

A decision was made in late 1991 to evaluate alcohol and other drug use among adolescents in Michigan and to assess the treatment services available to them. The Center for Substance Abuse Services determined that development of a statewide study group would be helpful in the analysis. Two subcommittees were formed to address the issues of access to treatment and quality of treatment. Prevention was not a focus of this study group because the Governor's Task Force on Drug-Exposed Infants was addressing substance abuse prevention among adolescents in its final report and recommendations.

The Center for Substance Abuse Services charged the Adolescent Study Group with making recommendations in the following areas: (Access Subcommittee) access, capacity, organization, distribution and financing of services; and (Quality Assurance Subcommittee) clinical requirements for quality service delivery, program standards, credentialing, contract and licensure standards.

Susan Becker, director of the Division for State Assistance, Office for Treatment Improvement, Washington, D.C., was invited to the first Adolescent Study Group meeting to address adolescent substance abuse. She emphasized that there are high risk adolescents (runaways, homeless, institutionalized people) who are missed by the national surveys, thus creating a picture that can understate actual use patterns. She explained how categorical programs are funded, with funding decisions often based on "mainstream America" research only. She said that local data should be included and used in compiling more accurate needs assessments and that coordination of the juvenile justice, social services, mental health and substance abuse systems is an issue that needs more attention.

Several other guest speakers addressed the Adolescent Study Group. Adolescents who had been in treatment also shared their ideas on important

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treatment components including length of treatment, the importance of family involvement, group counseling, successful intervention activities and aftercare.

The federal government also acknowledges adolescent substance abuse as a major health problem. In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, a national set of objectives to improve the health of the nation over the coming decade, several alcohol and other drug-related objectives for adolescents were identified: (a) establishing and monitoring the comprehensive plans of the 50 states to ensure access to alcohol and drug treatment programs for traditionally underserved people, (b) reducing the proportion of young people who have used alcohol, marijuana and cocaine in the past months, (c) decreasing alcohol use in youths ages 12-17 by 12.6 percent, ages 18-20 by 29 percent, (d) reducing marijuana use in youths ages 12-17 by 3.2 percent and cocaine use in youths ages 12-17 by 6 percent. These national objectives provide a foundation for each state to address adolescent substance abuse.

In the spring of 1992 the Adolescent Study Group conducted a survey of all states to gather information on adolescent services. Three questions were asked: Have any state-level groups been convened to discuss adolescent substance abuse services? Does your state have special licensing rules for adolescent substance abuse services? Does your state have special contractual requirements for programs providing adolescent substance abuse services?

The survey showed that there were 28 states that are meeting or have met at the state level to discuss adolescent substance abuse services. Fourteen states reported having special licensing rules for adolescent substance abuse programs. Twelve states reported having special contractual requirements for programs providing adolescent substance abuse services (See Appendix A).

EXTENT OF ADOLESCENT SUBSTANCE ABUSE PROBLEMS

Preliminary estimates from the 1992 National Household Survey on Drug Abuse indicate that drug use among 12-to-17-year-olds has decreased overall. Specifically, prevalence of illicit drug use among 12-to-17-year-olds has decreased from 9.2 percent in 1988 to 6.1 percent in 1992. The rates of use for marijuana and hashish were significantly lower for teens in 1992, 4 percent, compared to 6.4 percent in 1988. Cocaine use decreased from 1.1 percent in 1988 to 0.3 percent in 1992. There were no major changes in the prevalence of hallucinogens and heroin. Inhalants, however, had the highest rate (1.6 percent) of use for 12-to-17-year-olds. Alcohol use among that same age group decreased between 1991 and 1992 from 20.3 per-

cent to 15.7 percent (See chart below). (U.S. Department of Health and Human Services Public Health Service, Advance Report Number 3, June 1993).

juana, cocaine, crack, LSD, other hallucinogens, stimulants and inhalants (Johnston, April 13, 1993).

Even though heavy use of alcohol has declined among high school seniors, one must keep in mind that more than 87.5 percent of twelfth, 82.3 percent of tenth, and 69.3 percent of eighth grade students have used alcohol in their lifetime (See bar chart on this page) (Johnston, April 9, 1993). These are still significantly high percentages.

juana, uppers and cocaine. Seventy-five percent of Mexican American males and 90 percent of white American males had tried marijuana, and more than a third of the dropouts had tried cocaine. One-third of the Mexican American males and more than half of the females in both the Mexican Americans and white Americans group have tried uppers (Chavez, Edwards, & Oetting, 1989).

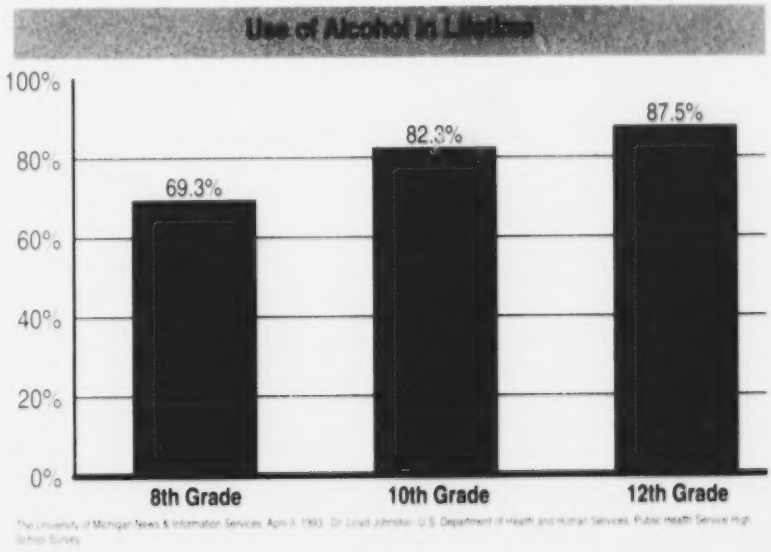
New substances with abuse potential are constantly becoming popular [DHHS Publication No. (ADM) 91-1813; 1991]. In addition, there has been an increase in the use of solvents inhalants such as correction fluid, disinfectant sprays, gasoline, hair sprays, butane, glues and nitrous oxide. Eighth-graders showed the widest use of inhalants (Johnston, 1993). There have been a number of deaths in Michigan resulting from inhalants use by teens.

	1988	1990	1991	1992
Illicit Drug Use	9.2	8.1	6.8	6.1
Marijuana	6.4	5.2	4.3	4.0
Cocaine	1.1	0.6	0.4	0.3
Alcohol	25.2	24.2	20.3	15.7

U.S. Department of Health and Human Services Public Health Service. Preliminary estimates from the 1992 National Household Survey on Drug Abuse. Advance Report Number 3. June 1993.

It is estimated that approximately 159,893 Michigan adolescents ages 12-17 are in need of substance abuse treatment (See Appendix B). MDPH CSAS 1989-1992 substance abuse treatment admission data indicate that there has been a decrease in admissions to publicly-funded treatment providers for alcohol, heroin, cocaine, crack cocaine, and marijuana hashish for youth under age 21 (See Appendix C). [A U.S. General Accounting Office report indicates that the National Household Survey on Drug Abuse provides conservative estimates of drug use. (U.S. General Accounting Office, Drug Use Measurement, June 1993)]

Although the overall trend for drinking has declined for sixth through twelfth grade, it appears that more seventh through ninth grade students have begun to drink at an earlier age. In addition, drugs of choice by eighth-graders were mari-



The University of Michigan News & Information Services, April 9, 1993. Dr. Lloyd Johnston, U.S. Department of Health and Human Services, Public Health Service High School Survey.

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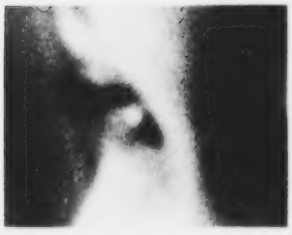
Access to Substance Abuse Treatment

CHARGE TO ACCESS SUBCOMMITTEE:

1. Determine the most appropriate etiological model for substance abusing adolescents available at present. Research seems to indicate that origins and maintainers of adolescent substance use and addiction differ from those of adults.
2. Determine the capacities of the various adolescent substance abuse treatment settings (residential, outpatient, intensive outpatient and others) in Michigan. Determine the cause, such as lack of need or lack of funding, if the capacity is low in certain geographic areas.
3. Determine how access to adolescent treatment services should be organized in Michigan (as a single statewide service, as a secondary and tertiary care network, as a local network, etc.).
4. Determine how services should be marketed to adolescents so they know the services are available. Decide who is responsible for this.
5. Determine what kinds of collaborative efforts are needed among agencies in order to deliver the appropriate care.

SURVEY OF STATE PROGRAMS

In the summer of 1992 the Adolescent Study Group conducted a survey of Michigan's inpatient, residential, outpatient and intensive outpatient substance abuse treatment services (See Appendix D). Questions were asked about capacity and utilization, whether or not the treatment program had a waiting list, unit cost of service and whether or not a program receives state funds. All of the service providers were informed about the Adolescent Study Group and asked to submit any information they felt was pertinent to the issues under examination.



The results of the survey indicated there are four facilities in Michigan that provide hospital-based inpatient services for adolescent substance abusers: Bay Haven Bay Medical Center, in Bay City; New Day Center Adventist Hospital, in Battle Creek; Munson Hospital, in Traverse City; and Marquette General Hospital, in Marquette. These programs represent a total of 53 inpatient beds for adolescents in Michigan. Their utilization rates range from 33 percent to 70 percent. It should be noted that this survey was taken in the summer when adolescent client admissions are usually down. None of the programs reported a waiting list,

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although Munson Hospital reported that at times they do have a waiting list. Three of the four inpatient programs receive state funds from their regional coordinating agencies. Adventist Hospital in Battle Creek does not receive state funds. The unit cost for inpatient services ranged from $200 per day to $600 per day. The costs for detoxification were slightly higher due to medical supervision costs.

There are ten residential facilities in Michigan serving adolescent substance abusers. The services for residential programs vary in intensity and include intensive residential, therapeutic residential and recovery residential. These facilities and their respective capacities include: Maplegrove (14 beds), in West Bloomfield; Ardmore Center (25 beds), in Livonia; Brighton Hospital (20 beds), in Brighton; Alpha House (16 beds), in Ann Arbor; Shiloh Family (11 beds), in Marquette; Lake Drive Recovery (9 beds), in Grand Rapids; Dakotah Family (12 beds), in Grand Rapids; Shiloh Family (15 beds), in Grand Rapids; Ojibway Group Home (5 beds), in Mt. Pleasant; and Alternatives for Girls (4 beds), in Detroit. The utilization rate of these facilities at the time of the survey in the summer of 1992 ranged from 40 percent to 100 percent. Four residential facilities reported having a waiting list. Seven of the 10 residential facilities receive state funds from their regional coordinating agencies. The unit cost ranged from a low of $82 per day to a high of $405 per day.

There are 16 outpatient programs in Michigan that specialize in adolescent substance abuse services. These services are located in Livonia, Plymouth, Brighton, Detroit, Ann Arbor, Battle Creek, East Lansing, Marquette, Grand Rapids, West Bloomfield, Grosse Pointe, Dearborn, Wyandotte and Kalamazoo. Other outpatient service providers in the state serve adolescents but do not have a specialized program. The utilization rates ranged from 50 percent to 100 percent with many programs contracting with additional counselors as the demand merits. The unit cost for individual counseling ranged from $45 to $96 per hour. The cost of providing service to each individual in group sessions ranged from $16 to $50 per hour.

Six Michigan programs provide intensive outpatient counseling services for adolescents. These programs are located in Trenton, Grand Haven, Kalamazoo, Plymouth, Flint and Livonia. These sessions run several hours a day for several days a week. The capacity of these programs ranges from 10 clients to 65 clients. Utilization rates were 50 percent to 90 percent. Three of these programs receive state funds from their regional coordinating agencies. The unit cost varies because some programs calculate a cost for the entire program while others calculate cost per day. The day costs vary from $85 per day to $175 per day. (Note: Some of the numbers have changed since the time of the survey.)

SPECIAL ATTENTION TO THE TREATMENT NEEDS OF HOMELESS, RUNAWAY & SCHOOL DROPOUT ADOLESCENTS IS NEEDED

REVIEW OF SPECIFIC ADOLESCENT SERVICE NEEDS

Substance abusing and chemically dependent* adolescents have unique needs and problems that are not adequately addressed in programs designed for adults. Treatment models specifically designed to serve the needs of adolescents and their families have only recently begun to be developed and can be expected to expand during the 1990s.

Special attention to the treatment needs of homeless, runaway and school dropout adolescents is needed (U.S. DHHS, Healthy People, 1990). For many young people, asking for help and accepting help are difficult tasks. Adolescents often have substance abuse problems that require access to clinically appropriate substance abuse services regardless of their legal status, willingness of parents to participate in treatment,

* Because substance abuse and chemical dependency have different definitions but are closely related, they are used together throughout the paper.

place of residence, family's ability to pay or other potential problems.

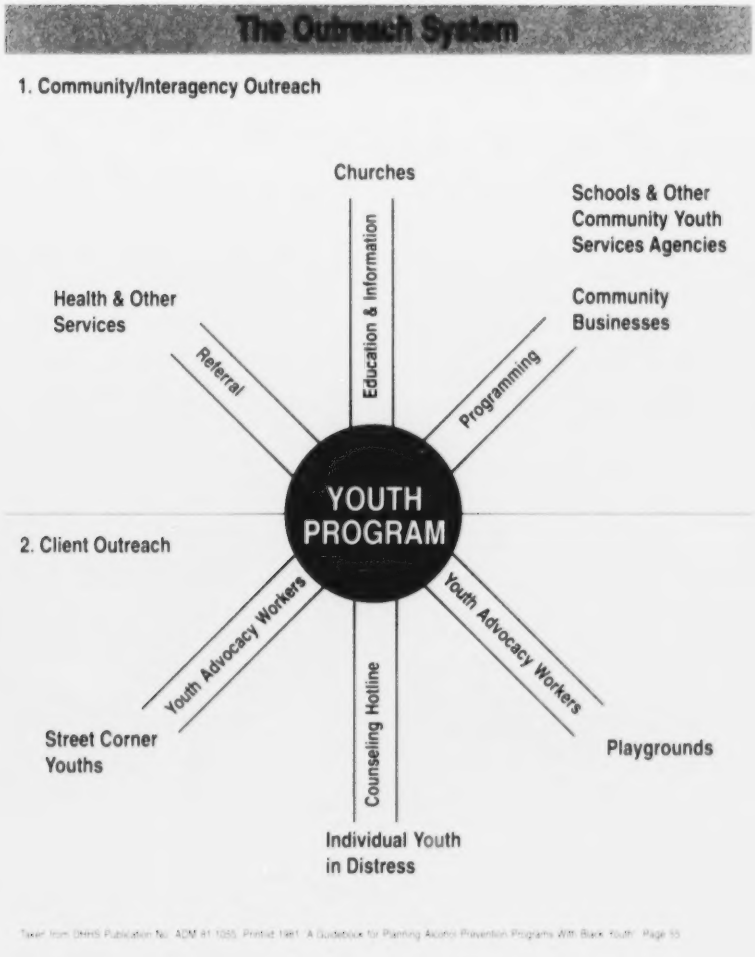
Access must be defined in terms of availability of a continuum of care including community-based services, prevention, outreach, high risk intervention, identification, screening, assessment, referral, 24-hour access to services, detoxification, inpatient, intensive residential, therapeutic residential, recovery residential, intensive outpatient, outpatient-individual, group, family, service coordination, aftercare and follow up.

Access to treatment involves providing a mechanism for adolescents to enter alcohol and other drug treatment services. The question "how can we get kids into treatment?" continues to be raised within the field. Access to care for adolescents is more than just opening the door; it requires persistence to get them into treatment and to keep them in treatment.

Community-based outreach services link the substance abusing/chemically dependent adolescent with community services, based on individual need. A systems approach to getting a job done is the process of drawing together concerned individuals, groups and agencies to achieve a particular goal. It involves the integration of activities on two levels: (1) community/interagency outreach—development of relationships with the community and with other agencies for support of programming and (2) program participation outreach—meeting youth where they are, in both a formal and informal setting [DHHS Publication No. (ADM) 81-1055; 1981].

The chart on the following page shows the combination of potential groups and agencies that make up the outreach system.

Because of associated risks, adolescent substance abuse should not reach the level of addiction before it is treated. Treatment at earlier stages requires early identification and re-



Taken from DHHS Publication No. ADM 81-1065. Printed 1981. A Guidebook for Planning Alcohol Prevention Programs With Black Youth. Page 55

ferral of adolescents to treatment programs. School personnel are critical links in the process of early identification of in-school youth.

A second key factor to access is providing information to the community about services available to adolescents and their families. Print and electronic media are important vehicles for community awareness. The subcommittee expressed a desire for aggressive outreach through publications, public service announcements and billboards on alcohol, tobacco and other drug (ATOD) services within communities.

PLANNING, OUTREACH SCREENING AND ASSESSMENT

A plan based on a needs assessment and the availability of resources and services in the region should be developed by all of Michigan's coordinating agencies. It should include a concise description of existing public and private services, and an annual plan of how adolescent substance abuse treatment services will be promoted, accessed and financed. The plan should also demonstrate how schools, courts, public health, mental health and social services will contribute to or facilitate access to care and financial resources. Implementation of the plan should include a coordinated and collaborative effort at both the state and regional levels.

Substance abuse should be included in the protocols for all health and mental health screenings. Screenings should be conducted at various sites that are accessible to the adolescent (i.e., home, school, court, primary health care providers—pediatricians, family practice physicians, nurse practitioners). Based on that screening, if further services are needed, the adolescent should have access to a comprehensive assessment.

A good history is a good foundation for an assessment. To be effective, the assessment and patient placement process for the adolescent must also include information from other systems such as family, schools, probate court, mental health, etc.; a personal interview to obtain the adolescent's perspective; objective assessment tools that can be used as a part of the overall assessment process; and involvement of trained professionals who have an extensive knowledge of adolescents.

An effective assessment will assure placement of the adolescent into the proper level of care. A new patient placement model developed by

the American Society of Addiction Medicine (ASAM) is used by many in the health care industry throughout the United States. The patient placement criteria for the treatment of substance use disorders reflect a clinical agreement of adult and adolescent treatment specialists. The patient placement criteria use a multidimensional approach to assessment to determine the most appropriate level of care for a patient. One of the unique features of the ASAM patient placement criteria is that they distinguish between adult and adolescent indicators.

In 1991, the federal Office for Treatment Improvement (OTI) sponsored an initiative to identify instruments to be used by practitioners to screen adolescents (ages 11-21) for substance abuse and related mental health problems, and to assess the degree of severity of the problems. The goal of the project was to assist professionals in the substance abuse field in accurately assessing substance abuse problems among adolescents. Two persons from the OTI study panel attended an Adolescent Study Group meeting.

The representatives of the OTI study panel reported that their project concluded that no single instrument could serve as a standard in treatment or other clinical settings. The panelists stressed the importance of a personal interview by a skilled clinician as part of the assessment process.

In reviewing methodological issues, the OTI panel stated that assessment tools must have sensitivity and specificity. That is, assessment tools must have the ability to recognize and correlate a number of factors and further identify the specific aspects of the substance abuse problem. Although the OTI study panel did not endorse any single instrument, the panel members recommended that a substance abuse assessment tool should have a public health focus.

Because of the difficulty in diagnosing substance abuse and chemical dependency in adolescents, the Access Subcommittee concluded that a comprehensive assessment should be conducted. A comprehensive assessment should include psychosocial history, sexual history, drug history, life skills evaluation, education history, psychiatric evaluation, medical evaluation and family evaluation [DHHS Publication No. (ADM) 91-1735; 1991]. The assessment tool for adolescents should consist of a standardized mechanism and a personal interview or interviews to include the family. The group recommended that all collaborative organizations having an interest in the adolescent should be included in the assessment.

A committee having much the same charge as the MDPH/CSAS Adolescent Study Group was convened by the State of North Carolina. According to the recommendations of the North Carolina Child and Adolescent Substance Abuse Planning Committee, the assessment process should ensure that adolescents are matched with the appropriate level of care for treatment services. In order to achieve this, the North Carolina committee recommended developing and implementing: (1) a criteria-based method to determine the appropriate level of care within the least restrictive environment; (2) guidelines to assist in selecting the appropriate treatment; (3) a mechanism whereby each adolescent is able to easily move among different levels of care within the treatment continuum as his/her treatment needs change; and (4) a plan to ensure that the length of treatment is flexible and appropriate, so that the duration is sufficient to provide a stable plan for recovery of the adolescent (North Carolina Department of Human Resources, 1992).

The Access Subcommittee concurs with the OTI panel in that the assessment tool should be culturally relevant and have proven validity, reliability and acceptability within the field. Further, the Access Subcommittee supports the language of the recommendations from the North Carolina committee.

Because the Adolescent Study Group sees the need for an adolescent service plan to be in place at all coordinating agencies, the following recommendations were made:

Recommendation #1

A plan should be developed by each regional coordinating agency for the provision of adolescent substance abuse treatment services.

Recommendation #2

Every adolescent and his/her family should have access to a screening for substance abuse services.

Recommendation #3

Based on the screening and/or assessment, adolescents should have access to comprehensive treatment services regardless of ability to pay.

Recommendation #4

Each school should have a teacher, counselor, or other professional identified and trained to screen and refer youth who exhibit high risk behaviors (i.e., truancy, juvenile delinquency) that may be linked to substance abuse.

Recommendation #5

There should be regional outreach programs to make adolescents and their families aware of services.

RESOURCES FOR SERVICES

Financing is also an access issue. Great progress has been made in identifying various funding sources for services for substance abuse clients. However, the financing for residential services must still be "pieced together" by seemingly complicated combinations of funding from MDPH/CSAS, Medicaid, Michigan Department of Social Services (DSS) child care programs and other sources. Although positive outcomes correlate directly with length of stay, funding is predominantly for short-term services and excludes family therapy.

In FY 1987/88 an invoice program was developed by means of an interdepartmental agreement established between MDPH/CSAS and the DSS Office of Children and Youth Services (OCYS). Through this $1,096,000 (Title XX) interdepartmental agreement, approximately $825,000 was transferred from OCYS to MDPH/CSAS to provide outpatient counseling services to all youth, with special consideration given to youth under the jurisdiction of the DSS or to youth who were in out-of-home placement and were referred to DSS through a court order. This program also funded outpatient substance abuse services to youth placed in training schools (Camp Nokomis and Shawono Center). This interdepartmental agreement ended at the close of FY 1990/91 due to DSS budget constraints.

Beginning in 1981, Medicaid-eligible recipients, including adolescents, were eligible for acute care detoxification and subacute "inpatient" (provided in licensed medical/surgical beds) substance abuse services. Through a $2.1 million interdepartmental agreement between MDPH/CSAS and DSS, state funds were used to support residential detoxification, residential, outpatient and intensive outpatient services to Medicaid recipients. Beginning April 1, 1991, reimbursement for all Medicaid substance abuse services was eliminated by DSS, except for acute care detoxification. Through MDPH/CSAS funds, Medicaid reimbursement was reinstated on May 1, 1991, for outpatient and intensive outpatient services for Medicaid-eligible recipients. Currently, there is no Medicaid reimbursement for residential services. Omnibus Budget Reconciliation Act (OBRA) regulations, which cover Early Periodic Screening, Detection and Treatment (EPSDT), require states to provide coverage for medically necessary services for Medicaid-eligible persons under age 21, even if this coverage is not currently part of the states' Medicaid plan.

The Access Subcommittee expressed concerns regarding the perception that payment for treatment services, particularly residential and inpatient treatment services, is often being denied by insurance companies and that public funds are being used to cover the costs of adolescent substance abuse treatment. Because of limited state and federal dollars, this perception should be investigated further by MDPH/CSAS to determine the effect on access to treatment.

Finally, overall hospital rates for medical care use decline after substance abuse treatment, representing substantial savings to health insurance providers or other payors (Hoffman, 1991). In a study conducted by the University of Minnesota, medical hospitalization rates for adolescents dropped by one-third in the first year after substance abuse treatment. Furthermore, hospitalization rates for detoxification declined after first year treatment, as did emergency room visits for illness and injury. It is clear that providing ad-

equate substance abuse treatment funding can drastically reduce the costs of extensive medical care and treatment. (Health care reform may improve access to care to all Americans by providing comprehensive coverage for substance abuse services. If substance abuse coverage is not provided as part of the new health care reform, society will pay far more for health care, due to the social and economic problems that result from alcohol, tobacco and other drug problems.)

The Center for Substance Abuse Services developed a summary of the projected needs for adolescent treatment services during FY 92/93. The charts on which the projected needs were based are located in Appendix C.

Based on the need for adolescent services and reimbursement for those services the following recommendations have been made:

Recommendation #6

State/federal dollars should be allocated based on adolescent treatment service plans that demonstrate a collaborative working relationship among human services agencies, courts and schools.

Recommendation #7

Medicaid reimbursement should be made available for all levels of treatment services based on a comprehensive assessment.

Recommendation #8

An ad hoc committee consisting of officials from service providers, the insurance commission and health insurance companies should be established to address reimbursement of substance abuse services for adolescents.

THE ADULT ADDICTION MODEL DOES NOT APPLY TO MOST ADOLESCENTS & SHOULD NOT BE USED IN A CLINICAL SETTING OR TO ESTABLISH PROGRAMMATIC OR FINANCING POLICIES

Recommendation #9

Title XX funding for substance abuse services should be restored to assist in payment for non-Medicaid eligible children.

ETIOLOGICAL MODELS FOR ADOLESCENT SUBSTANCE ABUSE TREATMENT

The adult addiction model does not apply to most adolescents and should not be used in a clinical setting or to establish programmatic or financing policies. Programs that serve adolescent chronic substance abusers should adopt a design that is intensive and of sufficient length to ensure that changes are internalized. The length of treatment should not be prescribed; rather, it should depend on variables such as severity of addiction, mental health and the adolescent's social context [DHHS Publication No. (ADM) 91-1744; 1991]. Furthermore, clinicians and treatment staff must be extremely sensitive to the uniqueness and needs of the 16-to-17-year-old adolescent. These adolescents are often treated as adults in other systems such as the criminal justice system.

DeLeon and Deitch, 1985, identified five key differences between treatment for adult and adolescent substance abusers. They are as follows: (1) Young clients have a higher incidence of disorganized family backgrounds; (2) young clients receive psychological treatment at an earlier age, including treatment after suicide attempts; (3) when deciding whether to stay in treatment, young clients are more likely to respond to pressures exerted by family and the fear of jail; (4) educational needs, the need for parental and family support and the provision of educational assistance play a larger role in the treatment of young chemical abusers; (5) the impact of the negative consequences of substance abuse is more apparent for adults. Adults suffer more tangible losses in money, family and

interpersonal relationships because they have abused drugs over longer periods.

Clinical and therapeutic approaches to treating the adolescent should address the whole person through comprehensive and integrated services.

Residential programs should include group activities. Many residential and clinic programs experience tremendous success that can be attributed to adolescents learning to interact with others in positive, supportive and cooperative ways.

Strong evidence suggests adult treatment models lack effectiveness with adolescents. Furthermore, theories also indicate that adolescents are developmentally different from adults and treatment protocols should therefore reflect the developmental needs of adolescents.

Based on the Access Subcommittee's discussion of adolescent treatment models, the following recommendations were made:

Recommendation #10

Diagnostic criteria, screening and assessment instruments used should be based on adolescent models of chemical dependency.

Recommendation #11

Treatment services should be community-based to the extent possible, including the provision of "in-home" and "family centered" care whenever possible.

Recommendation #12

Treatment services must be appropriate for age, developmental level, ethnicity, race and geography.

Recommendation #13

A state level ad hoc committee consisting of officials from MDPH/CSAS, probate courts, DSS and provider(s) should be established to address legal and other issues specific to delivery of services to adolescents.

CONTINUUM OF CARE AND ANCILLARY SERVICES

Assuring access to care after treatment includes access to a continuum of care and ancillary services that will preserve the therapeutic bonds established in treatment. Aftercare is an example of continuing care services to which access must be provided.

Aftercare is a critical component in treating adolescent substance abusers. Many youngsters who complete the initial phases of treatment relapse upon returning to their original environment. Strong transition and aftercare components can reduce the chance of relapse and help to ensure continuity of treatment goals.

Safety is a primary concern in treating adolescents. There is a need for foster homes that can provide safe living environments for adolescents who do not need intensive residential services but who do not have a safe home environment. Similarly, there is a need for safe, independent living settings for adolescents engaged in continuing care in the community.

In Portland, Oregon, the Morrison Center Breakthrough Program has a program component called Therapeutic Foster Care. If the adolescent's home environment is not conducive for successful recovery, proctor or foster families are used for alternative living arrangements for the adolescent instead of residential placement. The adolescents experience a drug-free home environment with families who are recovering and empathetic to the problems of the substance abusing adolescent. Proctor families have been in recovery for two

or more years, are certified foster care families and receive a subsidy from the Oregon Children Services Division. Some of the benefits of this particular model are that costs are less than residential treatment programs, foster parents can model behaviors and, if appropriate, help the adolescents work through a 12-step recovery program.

The Access Subcommittee discussed a need for a full continuum of care for adolescents and their families including early identification of potential substance abuse problems, assessment, referral for treatment, aftercare and follow-up services. The subcommittee recommends that such a continuum be available in every region of the state, either directly or on a formalized referral basis. Ancillary services were also considered by the subcommittee to be an integral part of this continuum of care. Services such as transportation and child care may be necessary for the adolescent to participate in any service component from treatment to aftercare.

Subcommittee members agreed that responsibility for the development of the continuum belongs at the regional level. The continuum must be culturally and geographically sensitive to the needs of the regions. The Access Subcommittee also suggests that new and creative treatment services for adolescents be explored in order to ensure that services for adolescents remain innovative and current. (Recommendations #1, #5 and #12)

AFTERCARE IS A CRITICAL COMPONENT IN TREATING ADOLESCENT SUBSTANCE ABUSERS

SERVICE COORDINATION/CASE MANAGEMENT

Service coordination is defined as a process that provides assessment of adolescents needs and planning for and monitoring of services. It includes linkage and coordination of resources and client advocacy. Service coordination as defined by the U.S. Joint Commission on Accreditation of Hospitals (Johnson & Rubin, 1983) has specific components including:

- coordinating an assessment of the adolescent's needs, focusing on the individual's abilities, strengths, needs and deficits;
- developing a plan designed to address the adolescent's service needs;
- assuring that the plan is implemented;
- linking the adolescent to appropriate services and assuring that services are coordinated; and
- monitoring service provisions and troubleshooting when problems arise.

Interventions, a Chicago-based health services corporation, is currently conducting a case management study. Limited availability of treatment openings at publicly funded programs, a client's lack of financial resources or health insurance and a client's lack of knowledge or skills to effectively maneuver through the treatment system were some of the treatment obstacles noted in the study. Through the referral, linking and advocacy process, case managers at Interventions have been able to reduce numerous obstacles and improve access to treatment (Greenhouse, 1992).

As part of the assessment process, the Access Subcommittee believes that a care manager should be assigned to each adolescent to advocate on behalf of the youth, to monitor the referral and to ensure that needed services are provided.

Recommendation #14

Treatment providers should assure that care management services are provided to adolescents.

Quality Assurance

CHARGE TO QUALITY ASSURANCE SUBCOMMITTEE:

1. Determine the most appropriate etiological models for adolescents (intervention, outpatient, residential, aftercare, home-based treatment prevention, outreach).
2. Determine what treatment modalities are age appropriate for adolescents (adult vs. adolescent modalities, gender specific).
3. Determine the minimum programmatic standards for adolescent assessment, treatment and follow-up care.
4. Determine if treatment includes assistance in managing the transition from adolescent to adult roles.
5. Identify how substance abuse programs can relate to areas of tobacco use, risk reduction for sexually transmitted diseases and other issues related to treatment.
6. Revise licensing rules for MDPH/CSAS to reflect age specific concerns and the special vulnerability of adolescents. Determine if licensing rules should be coordinated with DSS licensing regulations.
7. Determine certification and continuing education requirements for professionals working with adolescents.

Substance abuse in adolescents is a complex issue involving the interaction of genetic, biological and social factors (Conroy, 1988). Major factors that can lead to adolescent substance abuse include sexual, physical and emotional abuse. (Lopez, Redondo & Martin, 1989, and Toray, Coughlin, Vuchinich & Patricelli, 1991). The availability of substances also plays an important role in the substance abuse of an adolescent (Conroy, 1988). The physical and emotional damage created by substance abuse may depend on the adolescent's developmental life stage.

The National Adolescent Treatment Consortium Policy Statement #1 endorses the concept that alcoholism and chemical dependence are complex family illnesses in which an individual's ingestion of alcohol and/or other chemicals seriously and repeatedly interferes with health, school performance, family welfare and interpersonal relationships.

The National Adolescent Treatment Consortium Code of Ethics for treatment includes the following statements: (a) Specific admission and referral criteria are developed and adhered to for every level of services

provided; (b) quality treatment services are provided that appropriately meet the physical, emotional, social and spiritual needs of the patient and family; (c) treatment programs enhance the dignity and protect the human and legal rights of the patient and family; (d) aftercare services are considered essential to the continuum of care.

Adolescent services should be appropriate for the needs of young people and include services that address prevention, intervention and treatment needs. Comprehensive services will reduce barriers to treatment for young people with substance abuse problems by providing different avenues into treatment. Understanding the concerns of adolescents is essential in developing appropriate treatment programs.

Adolescents themselves described what substance abuse treatment should look like in remarks before the Adolescent Study Group. Adolescents who had completed treatment at various programs were invited to address the study group and provide input on what they felt should be included in substance abuse treatment programming. The adolescents indicated that treatment would not be successful until the adolescent admitted he she needed help. They felt that having staff available at all times to facilitate admission into treatment was very important. In addition, the adolescents indicated that therapy groups should not be a mix of adolescents and adults, but should be adolescents only. Most adolescent treatment providers agree that two additional important factors must be considered when providing treatment services to adolescents: (1) substance abuse treatment for adolescents should involve key family members and (2) aftercare services should be provided.

ADOLESCENTS INDICATED THAT THERAPY GROUPS SHOULD NOT BE A MIX OF ADOLESCENTS & ADULTS

Treatment begins with an accurate assessment that includes information from the family history, school and work environments. Analyzing the input from these sources will determine the level of treatment needed for a client. An adolescent experiencing fewer problems, may need less intense counseling. On the other hand, if an individual has either multiple or chronic problems he she may need more intense treatment. Referral to the appropriate level of care will assist with ensuring successful treatment for the adolescent (Golden & Schwartz Klein, 1987).

Treatment programs should consider the developmental stage or cognitive development of the adolescent in order to assure quality of treatment. Young adolescents are concrete thinkers and do not easily absorb abstract concepts. Treatment techniques, therefore, should increase awareness of cause and effect relationships. Older adolescents begin to develop insight skills and are more capable of extrapolating behavior into a series of consequences. Understanding such developmental factors can help with ensuring successful treatment outcomes.

TREATMENT MODELS

There are a number of different substance abuse treatment models throughout the United States, including crisis intervention, inpatient, residential, day treatment and outpatient programs. Placement of clients into the appropriate treatment setting depends on evaluating drug(s) used, length and extent of use, personality traits, home and school environment and other circumstances. Treatment programs have similar features such as offering individual, group and/or peer counseling and self-help 12-step groups. While family involvement in counseling is recommended, it may or may not be required. In addition, many programs have unique features such as culturally specific activities and foster care programs

[DHHS Publication No. (ADM) 91-1744; 1991].

In Michigan there are approximately 840 licensed substance abuse programs. As of December 1992, there were 4 inpatient, 16 outpatient, 6 intensive outpatient and 10 residential programs that provided substance abuse services specifically for adolescents (See Appendix D).

The MDPH CSAS FY 1992-93 Annual Action Plan defines substance abuse treatment services as follows: Outpatient services include individual, family and group therapy. Intensive outpatient (day treatment) services involve supervised rehabilitative and therapeutic services provided in a structured outpatient setting for a partial day of three or more hours. Intensive outpatient services are provided multiple days per week over a specific time period. Residential services may include detoxification (3-5 days), intensive residential (typically 30 days or less), therapeutic residential (typically exceeds 60 days) and recovery houses (typically six or more months). These different treatment modalities allow for different levels of care.

Treatment services specifically for adolescents are relatively new; therefore, there are no standard protocols for adolescent services. However, the following treatment components should be adolescent specific: program organization, treatment philosophies, counseling and psychotherapy techniques, and types of alternative activity programs (Friedman & Glickman, 1986).

The study cited above (Friedman & Glickman, 1986) illustrated that there are five types of program characteristics that enhance the reduction of drug use: (1) the size of the program; (2) special services (such as vocational, school and recreation); (3) types of psychotherapy used; (4) staff qualifications; and (5) perceptions of program environment.

Before making a recommendation on the most effective treatment model for adolescents, the Quality Assurance Subcommittee members identified essential components of a comprehensive treatment program for adolescents. A regional service plan that integrates a variety of program services to provide a continuum of services should include: community-based services, prevention, outreach, high risk intervention, identification, screening, assessment, referral, 24-hour access to services, detoxification, inpatient, intensive residential, therapeutic residential, recovery house, residential, intensive outpatient, outpatient-individual, group, family, service coordination, aftercare and follow-up.

After identifying the essential components of a comprehensive adolescent treatment prevention continuum, the Quality Assurance Subcommittee members looked at three different treatment models to use as a guide to identify adolescent treatment protocols. The first model was proposed by the Community Based Continuum of Care Task Force consisting of licensed substance abuse treatment providers in Genesee County. The providers represented the following substance abuse treatment programs: Transition House, Community Recovery Services, Connexion, Insight and Northwestern High School Adolescent Health Center.

The Community Based Continuum of Care Task Force discussed the categories of adolescents, insurance benefits, adolescent specific needs and standards for adolescent treatment. In addition, the task force identified adolescent problems related to outreach services, screening and evaluation, high risk intervention, outpatient treatment, day treatment, case management, aftercare, 24-hour services, regional halfway house, residential treatment, inpatient hospital treatment and detention center services.

The second model reviewed was the Brighton Hospital adolescent treatment program. A draft document from the Brighton adolescent treatment program described the specific needs of adolescents and specific requirements for level of care for residential and outpatient aftercare services. A comprehensive inpatient treatment modality was described.

The DSS Request for Proposal (RFP) for Day Treatment in Michigan was the third model used as a guide to identify adolescent treatment protocols. The DSS model described services not contained in the Community Based Continuum of Care Task Force recommendations or the Brighton Hospital model. The DSS RFP included a description of core program requirements for day treatment, tracking, post day treatment and wraparound services. The day treatment information provided a list of treatment needs, including education, recreation counseling, vocational training, family services and socialization.

The DSS RFP indicated tracking should be provided in a combination of three ways: face-to-face contacts, telephone verification and collateral contacts. A post day treatment model was suggested for individuals who successfully completed day treatment. It was encouraged that treatment also provide wraparound services which include a variety of supportive interventions that benefit the youth and family. The wraparound services fill basic needs that are often outside the mainstream of funding and case plan development.

The combination of these treatment models produced a comprehensive treatment model. The committee members agreed that a community may choose to use all or any combination of these models. The choice would depend on local health needs and resources. The committee also identified key components that are basic to all treatment models.

The following is a compilation of the three treatment models reviewed. It includes a description of treatment services for early risk intervention, outpatient, residential, inpatient, outreach services, continuing care aftercare, 24-hour services, juvenile correctional facilities and associated halfway houses and training schools.

Basic Recommended Components of All Treatment Programs:

- Family involvement in treatment
- Distinction between substance abuse and chemical dependency
- Thorough pre-admission assessment to determine level of care
- Medical screening, including sexually transmitted diseases (STDs), HIV/AIDS and TB testing
- Determination of and responsiveness to special needs (such as learning disability, hearing impairment)
- Individual counseling group counseling didactic therapy family and parent education family therapy interventions
- Appropriate use of psychotropic medications
- Least restrictive environment movement between levels of care
- Parent and sibling evaluation intervention
- Involvement of collateral and community support
- 12-step meetings while in the program
- Recreational social therapeutic program
- Spiritual growth program
- Peer modeling—e.g., alumni-recovering adolescents
- Frequent drug screening analysis
- Gender-sensitive clinical programs
- Culturally sensitive clinical programs
- Follow-up

Levels of Care

Additional treatment components have been identified as being necessary for each level of treatment.

Outpatient Treatment

- Longevity and follow-through
- Leisure time activities
- Transportation
- Adequate hours of treatment services
- One counselor for every 40 outpatient clients

Residential Treatment

- Educational programs
- Separate facility from adults
- One counselor for every six clients
- Detoxification services

Inpatient Hospital Treatment

- Specific chemical dependence component
- Separate facility from adults

Intensive Outpatient

- Transportation
- Separation of males and females once or twice a week to deal with gender related issues
- Literacy screening
- One counselor for every 12 clients—adolescents require more time and service coordination
- Work with schools and incorporate educational needs into treatment plan
- Accredited educational component
- Social skills development
- Conflict resolution skills training

Additional Support Services

Additional support services have been identified as being necessary for adolescents.

Continuing Care/Aftercare

- Continuing family aftercare for both clients and family
- Relapse prevention
- 12-step meetings

24-Hour Services

- Adolescent specific 24-hour crisis intervention hotline
- Written material targeted to adolescents and their families (should be locally distributed)

Extended Care Programs

- Male female specific services
- Help with re-entry into schools or work force

Juvenile Correctional Facilities

- Assessment
- Academic and vocational education
- Substance abuse education
- Aftercare referral

Based on the development of these adolescent specific models, the following recommendations were made:

[redacted]

The comprehensive adolescent treatment model recommended by the Quality Assurance Subcommittee should be adopted statewide and regionally.

[redacted]

Adolescents identified with sexually transmitted diseases should be offered HIV/AIDS testing.

[redacted]

Adolescent treatment programs should adopt abstinence from alcohol, tobacco and other drugs as a treatment goal.

UNIQUE TREATMENT PROGRAMS

Other program models not currently being used in Michigan also were reviewed and discussed as additional and unique models.

One unique long-term residential substance abuse treatment program is Peninsula Village in Louisville, TN. Peninsula Village has a national reputation and is recognized as a non-mainstream substance abuse treatment program. A tertiary acute care treatment center for adolescents who have completed an in-hospital program in a psychiatric or chemical dependency unit, the program is regarded as effective for 14-, 15- and 16-year-old teens to whom peer culture is important. Patients are housed in cabins in groups of ten patients per cabin. The treatment approach is group-oriented with emphasis on surrendering unrealistic self-absorption and dependency in exchange for practical life skills and healthy values. This is accomplished through positive peer pressure by the patient's group, as well as through a wide range of therapies and personal goal-setting. The program also has a fully accredited school emphasizing academics as well as vocational skills (Peninsula Village, Program Description and Treatment Philosophy).

[redacted]

Innovative program models should be developed for adolescent care which build on the recommended treatment components.

TREATMENT METHODS

The Quality Assurance Subcommittee members endorse the following definition of recovery as part of treatment protocols: Recovery is an ongoing process that involves the absence of all mood-altering chemicals, obsessive thinking, self-destructive obsessive and compulsive behavior and the reduction of psychosocial harm to self and others.

Research indicates that treatment programs generally have used the same treatment methods for adolescents and adults. However, treatment providers should be sensitive to the unique needs of adolescents. Treatment programs should offer creative, culturally competent services that will keep adolescents in treatment.

Adolescents themselves play an important role in treatment. Research shows that unless clients are motivated they will not remain in treatment. Assistance must be provided in meeting adolescents' personal goals and overcoming deficits. Skills training and problem solving, as well as other psychosocial therapies, can help with rehabilitating a substance abusing adolescent (Catalano, Hawkins, Wells, Miller, & Brewer, 1990-91).

In order to assure quality of service, adolescents entering treatment must be provided with information on the rights they have as clients. The Quality Assurance Subcommittee members believe that each adolescent has the right to have information that would allow him her to make informed consent decisions regarding treatment. Therefore, the following recommendations were made:

[redacted]

All future substance abuse materials written by MDPH CSAS used in adolescent substance abuse treatment, including the "Know Your Rights" brochure and treatment consent forms, should be written so that adolescents can easily comprehend their content.

[redacted]

The Center for Substance Abuse Services should develop a video that outlines and explains the rights of an adolescent in substance abuse treatment.

ROLE OF THE FAMILY IN TREATMENT OF AN ADOLESCENT

An adolescent substance abuse problem is a family problem. Adolescents who spoke at one of the first meetings of the study group indicated they felt that family involvement was very important. In addition, research clearly shows that family involvement in adolescent substance abuse therapy enhances treatment outcomes (Todd, 1991).

The family is recognized as the primary source of meaning and influence and, therefore, a source of power to produce and sustain change. The family may be the only stabilizing factor in an adolescent's life. Concerted efforts should be made to obtain and maintain involvement of family members in the treatment of adolescents.

Prior to the sixties and early seventies, families were not considered an important part of treatment of the adolescent.

Today, a "family-centered" approach in substance abuse treatment is growing. Involving the families in the treatment of adolescents can add the support and love needed for recovery [DHHS Publication No. (ADM) 92-1745; 1992].

Family-centered programs vary in size and scope across the country. Delaware's Children Services Department is implementing statewide changes to include a family focus in adolescent services. Both outpatient and residential alcohol and drug abuse treatment programs are also increasingly including families in the treatment of adolescents [DHHS Publication No. (ADM) 92-1745; 1992].

Home-based family intervention programs are growing throughout the United States. Studies indicate that home-based family service programs are more efficient and cost-effective. The goal of home-based family intervention programs is to prevent family break-up and out-of-home placement of the adolescent while strengthening and maintaining family members to become more self-sufficient (Bryce & Lloyd, 1980). Benefits of home-based family interventions include: easier access to family, more accurate assessment, observable behaviors, whole family impact and easier facilitation of case management.

However, there are some situations in which parents are not encouraged to be a part of an adolescent's treatment because of the parents' physically or emotionally destructive behavior. Parents who abuse drugs themselves or engage in criminal activity are not likely to be productive participants in the treatment process. It may then be more appropriate to involve another responsible significant adult in a parental support role.

AN ADOLESCENT SUBSTANCE ABUSE PROBLEM IS A FAMILY PROBLEM

The Quality Assurance Subcommittee members acknowledge the family role in the adolescent's rehabilitative outcome. Involving the family can strengthen the ability to cope with the adolescent and increase the chances of a more complete recovery of the adolescent.

Currently, Medicaid and other third-party payors do not reimburse for family therapy. This reduces incentives for family involvement in the treatment plan for adolescents.

Recommendation #21

Adolescent treatment programs should be family centered. Because the family is recognized as a source of power to produce and sustain change, concerted efforts should be made to get involvement of family members in the treatment of adolescents.

Recommendation #22

All third-party payors should reimburse for related family treatment and reimbursement rates for these services should be adequate to cover costs.

GENDER SPECIFIC ISSUES

A few studies have been conducted that analyze the difference seen in male and female adolescent substance abusers. By understanding gender differences in adolescent substance abusing populations, educators and clinicians will be able to provide better treatment and prevention services.

A study conducted by Ensminger, Brown and Kellam (1982), showed that adolescent males and females have different behaviors that can be predictive of later substance use. For instance, early aggressive or shy-aggressive behavior was found to be predictive of later heavy substance use for males, whereas lack of family bonds was more predictive for females.

American males and females have different biological, psychological and social characteristics, which contribute to different routes for substance abuse. One example of this is

the difference in response to stress by males and females. Males tend to respond to stress with aggression while females tend to internalize it. In addition, there tends to be a lot of denial of substance abuse by females. They may therefore have less access to treatment and services (Toray, Coughlin, Vuchinich & Patricelli, 1991).

There is some indication that men outnumber women in treatment (Furst, Beckman, Nakamura & Weiss, 1980). It has been suggested that this may be due to the fact that females are less likely to disclose their substance abuse problems. Also, women tend more often to be referred to treatment by family members and friends. However, because family members may frequently oppose the females entrance into treatment, this leaves them with fewer referral sources. (Toray, Coughlin, Vuchinich & Patricelli, 1991).

Males and females also tend to exhibit different psychological profiles. Research shows that females tend to drink to get away from emotional pain such as anxiety or loneliness. In addition, compared to males, female substance abusers have higher rates of depression, and other affective disorders and have a higher rate of suicide attempts (Toray, Coughlin, Vuchinich & Patricelli, 1991).

Adolescents who have been sexually abused are more likely to have a substance abuse problem (Hernandez, 1992, and Singer, Petchers, Hussey, 1989). Females show a much higher incidence of physical and sexual abuse than males. Data indicate that up to 53 percent of all alcoholic women report incest or other childhood sexual abuse (Covington, 1982). If females are taking substances as a means of coping with physical or sexual abuse, then treatment programs need to address these issues.

It is suggested that a blending of family therapy with feminist therapy may help to address a number of sex-role issues facing females in their recovery. Issues such as assertiveness training, gender-based power inequities within families, social stigmatization of the female substance abuser and high rates of depression and suicide attempts among females can be addressed in feminist family therapy. This type of therapy may help with the self-blame and stigmatization that are often felt (Chaney & Piercy, 1988, and Nichols, 1985).

It has also been suggested that treatment for females who abuse drugs and who have been sexually or physically abused should proceed in phases, beginning with individual treatment and moving to family therapy once trust and support have been established with the therapist. Group therapy with males and females together may limit the opportunity for such sensitive matters as sexual victimization to be brought up and discussed (James & Nasjleti, 1983).

Because of the higher rates of depression and suicide for female substance abusers, treatment should also involve psychological assessment and screening upon entrance into treatment (Toray, Coughlin, Vuchinich & Patricelli, 1991).

Therapists who deal with adolescent female substance abusers have reported that aftercare available to a female after the completion of treatment may lack sensitivity to a number of issues related to stigmatization and sexual victimization.

The stigmatization felt by many recovering female adolescents may lessen their compliance in attending aftercare groups. Females may have difficulty in 12-step program models such as Alcoholics Anonymous and Narcotics Anonymous because both are dominated by male participation. Females may feel stigmatized and uncomfortable with working through issues related to victimization (Toray, Coughlin, Vuchinich & Patricelli, 1991). In conclusion, adolescent female substance abusers may be confronted with psychological, family and cultural roadblocks in recovery not encountered by males.

Homosexuality may add to the substance abuse problem for adolescents. Homosexual males and females generally become aware of their homosexual feelings between the ages of 13 and 16 (Troiden, 1988). Adolescent homosexuals are often dealing with self-esteem issues and may be ridiculed by peers. The need for substance abuse treatment services in Michigan for the lesbian/gay/bisexual community are often ignored. Homosexuals need a safe environment where they can deal with their homosexuality and substance abuse problem.

Adolescent treatment programs should be gender sensitive and address the special needs of homosexual adolescents.

EDUCATION/STUDENT ASSISTANCE PROGRAMS

Substance abuse negatively affects attachment to school. Alcohol and other drug use is associated with underachievement and greater risk of dropping out (Ensminger, Brown & Kellam, 1982). Studies show that use of cigarettes, marijuana and other illicit drugs at any age increases the likelihood of dropping out of school, which indicates that dropping out of school is a partial function of drug use itself (Mensch & Kandel, 1988). Academic performance and poor socialization are predictors in determining who drops out of high school. Whatever predisposing factors may foster various behaviors, drug use plays a significant role in increasing the risk of a student leaving school.

DRUG USE PLAYS A SIGNIFICANT ROLE IN INCREASING THE RISK OF A STUDENT LEAVING SCHOOL

Although little research has been done in the area of educational interventions for substance abusers, research associated with teaching approaches for mildly handicapped learners can assist with identifying teaching approaches for substance abusers. Educational interventions have been shown to restore good school performance and reduce post-treatment relapse for substance abusers. Effective teaching, first and foremost, includes teachers who believe in the student's ability to learn. Teaching approaches that provide students with a greater opportunity to learn through content exposure and more time devoted to academic instruction also produce greater achievement. In addition, achievement is higher when both teachers and students are actively involved with a lecture, when the teacher constantly monitors the student's understanding of the material, and when the teacher prepares students so that questions are met with right answers (Catalano, Hawkins, Wells, Miller & Brewer, 1990-91). An educational environment that is warm, supportive, encourages effort and offers praise can lead to academic success for substance abusers.

Along with education, recreational services are also related to the reduction of drug use during treatment. Recreational approaches report positive results in school attendance, positive attitude toward school, im-

provement in behavior, reduction in criminal offenses, and improvement in self-concept.

Approximately one half of Michigan's junior and senior high schools have Student Assistance Programs (SAPs) to help substance abusing students in school and to assist those who are returning to school from treatment. Student Assistant Programs are funded through a variety of state and federal funds. The Michigan Guide to School Policies and Programs on Alcohol and Other Drugs developed by the Michigan Department of Education in cooperation with MDPH/CSAS has identified 17 major dimensions of the intervention process for Student Assistance Programs. Currently, the Office of Drug Control Policy (ODCP) is developing a training manual for Student Assistance Programs. In addition, the State Board of Education has developed a position statement for Student Assistance Programs.

The effectiveness of Student Assistance Programs varies throughout Michigan. There has been concern by the Quality Assurance Subcommittee that teachers may not be referring adolescents who have a substance abuse problem. Other concerns raised regarding SAPs include issues on financial barriers and confidentiality.

After much discussion, it was decided that Student Assistance Programs are a necessary component for substance abuse treatment, but that they should be monitored more closely. The committee reviewed Georgia's Department of Human Resources Student Assistance Program standards. From these standards, the Quality Assurance Subcommittee has proposed some Michigan Student Assistance Standards (Appendix G, General Provisions For Programs Providing Student/Family Services). Further, the committee made the following recommendation:

Recommendation #24

MDPH/CSAS should work with the Department of Education to implement the Michigan Student Assistance Program standards.

PEERS

Substance users often exhibit a strong attachment to peers. Peer influences have been shown to be a strong contributor to alcohol and other drug use among adolescents. However, just as peers can be an influence in leading a person to abusing

substances, they can help rehabilitate an adolescent substance abuser. Involving peers in treatment can help the substance abusing adolescent get back on the right track and stay drug free (Duda, 1980). Unfortunately, many times adolescents are placed in adult programs where other patients are twice their age and staff lack expertise on adolescents (Byalin, Smith, Chatkin & Wilmot, 1987).

A survey was conducted by the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) on peer influence as a factor for introduction of people to substance abuse treatment. The survey indicated that 61 percent of 44 substance abusing individuals in treatment were approached by their friends about their problem. Peers of adolescents who abuse substances can be effective advocates for healthy behaviors and should be encouraged to approach peers about their substance abuse problem (Duda, 1980).

Adolescents from treatment programs in Michigan who spoke to the study group indicated that peer counselors were an important part of treatment. The adolescents said they felt freer to talk to peer counselors. They reported that peer counselors were quicker to confront an adolescent if he/she was not being open or honest because they had been through it themselves and could talk to the substance abusing adolescent in his/her own language.

Very little research has been done on the efficacy of using peers in family therapy. Selekman (1991) identified three peer intervention strategies to assist an adolescent with substance abuse treatment. The first peer intervention strategy is to assist in building trust between parents and adolescents. Often parents believe that peers are responsible for their child's substance abuse problem. However, most of the time parents are quite surprised to discover their child's peers are responsible, good students. The family/peer group sessions contribute greatly to rebuilding a sense of trust.

The second peer intervention strategy is to use the peer group as a consultation team. Here peers assist with identifying and resolving problems between the adolescent and his/her parents. Peers can offer new and useful ways to look at problem situations and peers, clients and parents can work together to resolve problems.

The third peer intervention strategy is using peer groups as a relapse prevention support system. Many adolescent substance abusers dislike attending Alcoholics Anonymous or Narcotics Anonymous because those programs do not fit with the developmental norms and values of the adolescent culture (Glassner, Carpenter & Berg, 1986). Peers are a natural support system for adolescent substance abusers. They can help with decreasing the adolescent substance abuser's chemical use by being available on a daily basis for support.

Although peers can help rehabilitate a substance abusing and/or chemically dependent adolescent, there are two situations in which peer involvement in family therapy is not encouraged. One is if the client's peers are involved in drugs or delinquent behavior. The second is if the family situation is chaotic and abusive. In this situation, peer involvement could add to the disorder in the family.

Recommendation #25

Peers should be involved, as appropriate, in treatment of adolescent substance abusers.

AFTERCARE

Although it is not known what specific elements lead to a high relapse rate, the existence of an aftercare program is associated with lower relapse rates (Catalano, Hawkins, Wells, Miller & Brewer, 1990-91). There are a number of self-help programs available that can be accessed during aftercare. Some of the more common programs are Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Cocaine Anonymous (CA). Relapse prevention programs enhance the individual's chances of recovery as well as preserve treatment gains.

The results of a study conducted by Shoemaker and Sherry in 1991 demonstrated the importance of considering post-treatment environmental and psychological factors in understanding adolescent substance abuse treatment outcomes.

Testimony from adolescents currently in treatment for substance abuse indicated that aftercare was very important to them, because adolescents need somewhere to go and someone to talk to after formal treatment is finished. In addition, the adolescents felt aftercare was very important to keep them off

drugs and to learn how to manage in the world.

Subcommittee members noted that aftercare groups are needed in schools to increase the chances that returning adolescents remain drug-free.

After studying factors associated with relapse and existing aftercare methods, Hawkins and Catalano (1990-91) offered the following recommendations for aftercare. It should:

1. Increase family and other social support for living in the community without dependence on drugs and should seek to eliminate patterns of interaction with family and peers that contribute to readdiction.

2. Seek to increase involvement in productive roles in the community, whether in work, school or home.

3. Involve former abusers in active recreational and leisure activities that do not involve the use of drugs.

4. Assist former drug abusers to develop and practice a set of specific skills. These are (a) the skills necessary to become involved in social, productive and leisure activities in the larger community; (b) the skills to cope with stress and "negative emotional states" without resorting to drug use as a form of self-medication; and (c) the skills to cope with a slip into drug use without allowing it to become a full-blown relapse.

Two post-treatment correlates found as predictors of relapse are lack of involvement in education and recreational services. Interestingly, these two factors are also predictive in pretreatment and during treatment. Behavioral and cognitive skills training can assist treatment clients to reduce drug cravings and increase their social skills to establish non-drug using social contacts in work and school settings. This may reduce the possibility of a relapse.

IT IS ESTIMATED THAT 55% TO 60% OF ADOLESCENTS IN TREATMENT HAVE BEEN THROUGH THE COURT SYSTEM

The National Adolescent Treatment Consortium Policy Statement #1 states that a person with alcoholism and or chemical dependency cannot return to the use of alcohol or other mood altering chemicals. It further states that the primary goals in treatment are to help assure that the individual strives to sustain abstinence and, together with family members, seeks a more meaningful, satisfying and productive way of life in recovery.

Adolescent substance abuse treatment programs should assure that clients receive comprehensive aftercare.

Aftercare programs should be provided in schools for returning adolescents to reduce relapse.

JUVENILE JUSTICE/ COURTS

It is estimated that 55 percent to 60 percent of adolescents in treatment have been through the court system. The National Council Survey indicated that 60 percent to 90 percent of all juvenile justice cases are related to alcohol and other drugs (Metropolitan Court Judge's Committee Report, 1988). Consequently, courts can play a vital role in substance abuse treatment efforts.

In 1987, a working conference on juvenile and family substance abuse prepared a report and developed recommendations for the National Council of Juvenile and Family Court Judges to heighten awareness of substance use and abuse. The report identifies 12 risk factors for delinquency and drug abuse, recommendations for courts, assessment and treatment recommendations, and recommendations for youth gang and large-scale criminal drug trafficking (See Appendix E).

Judge Faye Harrison, Saginaw County Probate Court,

Juvenile Division, and a member of the Adolescent Study Group, stated at a study group meeting that adolescents ages 13, 14 and 15 going through her court were there because of distribution of drugs and that adolescents as young as 11 were in court for use of drugs. Judge Harrison further stated that children, from birth on, have been the subject of neglect proceedings in her court because of drug use by parents. She noted that sanctions against the family are often not feasible because many families are not able to meet court requirements such as seeking counseling, getting a drug test, or having an assessment, because these services may not be available. Therefore, there is often no way for the court to impose an effective sanction. She added that the community as a whole needs information and training for better results when adolescents are released from the courts.

Foster care may be necessary when juveniles are removed from the custody of their parents by the courts because of neglect, abuse, inadequate care or juvenile delinquency. Foster care offers offenders more consistent discipline and guidance from understanding adults in order to overcome delinquent behavior.

Project Choices is a unique drug treatment program in the state of Georgia for court-referred youth. The philosophy of Project Choices uses adventure-based counseling techniques to encourage young people to develop positive social behaviors and decrease drug abuse behaviors. The action-oriented experiences commonly referred to as "challenge rope courses" include physical challenges that are both individually and group focused. With these activities individuals are required to achieve specific educational or therapeutic goals. Clients in Project Choices are encouraged to develop increased self-esteem, learn positive coping skills, improve relationships with their families and value their ability to live drug-free

when returning to their home environments. Studies show this program has an 85 percent success rate after six months for adjudicated youth (Gillis & Simpson, 1991).

A Jail Addiction Services (JAS) program in Montgomery County, near Washington D.C., gets drug-abusing inmates into treatment before they go to trial. In addition, JAS also arranges for its patients to continue treatment at public or private facilities once they are released. Faye S. Taxman, acting director of the county's criminal justice coordinating commission, indicated that although this program does not reduce the number of people convicted, it reduces jail crowding because more people are able to get parole or probation.

Recommendation #28

The court system should consider sending an adolescent to substance abuse treatment prior to placement in a correctional facility. All staff in residential programs serving juvenile offenders should receive training in early identification of possible substance abuse problems and make appropriate referrals for assessments.

SUBSTANCE ABUSE AND NICOTINE USE

American businesses experience employees abusing alcohol and drugs on the job. Substance abuse in the workplace affects employee health, safety, productivity and health care costs (U.S. Department of Labor, October 1991). An employer can reduce the risks of employees' drug use by having a Drug-Free Workplace program in place. A comprehensive Drug-Free Workplace program consists of a written substance abuse policy, an employee education and awareness program, a supervisor training program, an Employee Assistance Program and a drug testing program, as appropriate.

NICOTINE ADDICTION SHOULD BE ADDRESSED IN THE MASTER TREATMENT PLAN & WITHIN THE CONTINUUM OF CARE

Tobacco is considered a gateway drug toward the use of alcohol and other drugs. Unfortunately, many substance abuse treatment programs do not place emphasis on discouraging tobacco use by clients. This may be due to the fact that treatment professionals may feel that this would lead to more clients leaving before completing treatment.

Policy Statement #5 of the National Adolescent Treatment Consortium (NATC) endorses nicotine-free treatment as the standard for the adolescent. NATC views nicotine as addictive and a major health risk. Nicotine addiction should be addressed in the master treatment plan and within the continuum of care. Adolescent treatment providers should not use nicotine as a reward in behavioral management programs. The staff should role model appropriate nicotine-free behavior and should be provided appropriate health promotion programs as necessary. A smoke-free environment with designated smoking areas should, at the very least, be provided. The Quality Assurance Subcommittee members agree that treatment programs serving adolescents must be smoke-free.

In addition, the 1992 ADAMHA Reorganization Act states that for FY 1994 and subsequent years, block grant awards are contingent upon the enactment and enforcement of state laws that prohibit the sale of tobacco products to minors. Specifically:

1. States will lose 10 percent of their block grant funding beginning in FY 1994 if they do not comply with the tobacco products provisions.

2. States will lose an increased percentage (20 percent, 30 percent and 40 percent) in

each of the subsequent years for noncompliance.

Recommendation #29

All licensed substance abuse treatment programs should have a comprehensive Drug-Free Workplace program in place.

Recommendation #30

All substance abuse treatment programs serving adolescents should be tobacco-free and should coordinate treatment services with a tobacco cessation program such as the American Lung Association's "Tobacco-Free Teens" program (See Appendix F).

LICENSING

To meet minimal standards of care, all programs (public and private) providing substance abuse services are required by Michigan Public Act 368 of 1978 to be licensed by the Center for Substance Abuse Services. Programs providing services to adolescents in residential and inpatient settings also need to be licensed by the DSS Child Welfare Licensing Office. MDPH-CSAS and DSS are working cooperatively to ensure that adolescents are receiving adequate care.

The following are categories of service for which programs are licensed: inpatient, intensive outpatient, outpatient, prevention, residential, residential (sub-acute detoxification). In addition, facilities can receive a screening, assessment, referral and follow-up (SARF) license. To provide adolescent specific licensing rules, the Quality Assurance Subcommittee members provided input on draft rules. Prior to developing new licensing rules, the Quality Assurance Subcommittee reviewed the licensing rules of more than 28 other states. Also reviewed were CSAS licensing rules, DSS child care licensing rules and Joint Commission on Accreditation of Health Care Organizations standards.

The Quality Assurance Subcommittee used the following guidelines for developing adolescent specific licensing rules for Michigan:

1. Licensing rules that reflect age specific issues of adolescents.

2. Licensing rules that complement DSS regulations.

3. Licensing rules that require that programs incorporate role transition from adolescence to adulthood.

4. Licensing rules which mandate that adolescent substance abuse service agencies incorporate prevention and awareness programs in the areas of tobacco cessation, STD risk reduction, HIV/AIDS, sexuality, sexual abuse and other issues related to treatment.

The Quality Assurance Subcommittee's draft of the rules pertaining to adolescent treatment is contained in Appendix G.

Recommendation #31

Adolescent specific and associated licensing rules as shown in Appendix G should be adopted.

CERTIFICATION

Another successful component of adolescent treatment programs is an experienced staff. The greater the client's regard for staff, the better the drug treatment outcome.

The National Adolescent Treatment Consortium Policy Statement #1 states that personal responsibility and accountability should be underscored in treatment to lead to a successful recovery. Treatment providers, on the other hand, should assume responsibility and accountability for treatment services, management practices, facilities, relationships and marketing.

Treatment should include a multidisciplinary team consisting of a licensed counselor, physician, psychologist, social worker, registered nurse, family therapist, activities therapist, spiritual counselor, certified teacher, recovering addiction specialist and an adolescent psychiatrist.

Currently in Michigan, individuals who provide direct services in treatment programs that receive state funds must have one of the following: a Fundamentals of Substance Abuse Counselor (FSAC) certificate, licensure as a physician or psychologist, a master's degree in guidance and counseling or social work, or 16 college-level semester hours of substance abuse-specific course work.

The Quality Assurance Subcommittee agreed that since the Certified Addiction Counselor (CAC) certification is already

in place, it may be possible to add adolescent specific skills and experience to the training.

Currently, treatment programs serving adolescents are not uniform in their personnel qualification requirements. Job descriptions from several adolescent providers were reviewed to determine requirements of the different clinical personnel who work with adolescents. It was concluded recommended that each adolescent program should employ one clinical staff person who possesses a Certified Addiction Counselor certificate or its equivalent for every 6 residential clients, one for every 40 clients in outpatient treatment and a ratio of not less than one family therapist to every 12 clients in intensive outpatient treatment. Certification is recommended to maintain uniformity in programs. It was determined each residential adolescent program should employ the following professionals: Clinical supervisor, counselor technician and an adolescent addiction specialist.

The Quality Assurance Subcommittee recommended that core courses of an accredited university substance abuse program should include basic counseling techniques, group and family therapy, general psychology, human development and chemical dependency of adolescents. Currently, there are three universities in Michigan that offer specific substance abuse addiction studies programs. They are Wayne State University, Western Michigan University and the University of Detroit-Mercy. In addition, several other Michigan colleges and universities offer substance abuse courses.

The Quality Assurance Subcommittee members developed the following recommendations for professionals working with adolescent programs:

[redacted]

Agencies that provide adolescent substance abuse services should employ one full-time clinical staff person possessing a specialty certification for (a) every 40 outpatient clients, (b) every 6 residential clients, and (c) every 12 clients in intensive outpatient treatment.

[redacted]

An adolescent addiction specialist certificate should be established to recognize professionals who possess degrees or graduate certificates from accredited universities or colleges with core courses which have been identified as necessary in an adolescent substance abuse treatment component.

glossary

ADDICTION

The force behind chemical dependency. The individual has lost the power of choice. Once the decision is made to use the individual chemical of choice, then the drug makes the choice. The individual loses the ability to use in moderation and/or the ability to use predictably.

ADMISSION

The point at which an individual is formally accepted into a substance abuse treatment program and services are initiated.

ADOLESCENT

A young person in the process of maturing. The early adolescent is generally between the ages of 10 and 13, the middle adolescent is between the ages of 14 and 16 and the older adolescent is between the ages of 17 and 21.

ANCILLARY SERVICES

Subordinate or subsidiary services.

ASSESSMENT

A comprehensive examination of a substance abusing or chemically dependent individual to determine appropriate need for level of care.

CASE MANAGEMENT/SERVICE COORDINATION

A service that provides assessment of adolescents' needs and planning and monitoring of services. It includes linkage and coordination of resources and client advocacy. Case management addresses adolescents' social, health, educational, vocational, housing and financial needs.

CHEMICAL DEPENDENCY *

A pathologic response of a person to a mood-altering chemical substance, or a psychoactive drug, in expectation of a rewarding experience. The rewarding experience is the intoxication or high.

* Because substance abuse and chemical dependency have different definitions but are closely related, they are used together throughout the paper.

CONTINUING CARE

The process of providing treatment and/or other supportive services to a client who has met the initial goals and objectives of his/her treatment plan and no longer requires daily, weekly or monthly counseling services provided by a program. Care continues on an as-needed basis to support and increase the gains made during treatment.

COMMUNITY BASED OUTREACH

An activity or series of interrelated activities within a cultural environment.

CLINICAL SUPERVISOR

The program staff person who has responsibility for the design, implementation, staff training and/or clinical maintenance of the substance abuse treatment practices in the program, including, but not limited to, psychosocial assessments, treatment planning format, reviews of treatment plans, progress notes and discharge summaries.

EARLY INTERVENTION

A service designed to delay the onset or reduce the severity of substance abuse problems among adolescents. This service is directed to adolescents who are at risk for developing substance abuse problems due to environmental circumstances, such as teen pregnancy, school failure, juvenile delinquency or economic circumstances.

EXTENDED CARE PROGRAMS

Programs that combine day treatment, on-site student educational services and group living. Day treatment and educational services are provided off-site but are highly integrated into the overall program of services. Evening and weekend programming include supervision and therapeutic services, such as home living skills and leisure time activities.

FAMILY-CENTERED

Services that are centered around the family as the unit of concern.

FOLLOW-UP

Activities designed to determine the present status of persons previously discharged by a program or referred by that program to services from another program.

FULL-TIME EMPLOYMENT

Employment that is not less than 35 hours per week.

INPATIENT CARE

A substance abuse and or chemical dependency treatment service that is provided to persons within a hospital setting under medical supervision. Inpatient care includes emergency services and nonemergency services.

INTENSIVE OUTPATIENT (DAY TREATMENT)

Supervised rehabilitative and therapeutic services provided in a structured outpatient setting for a partial day of three or more hours. Services are provided multiple days per week over a specific time period as determined by program design and the client's need and treatment plan. Individualized care appropriate to the client's age, development and presenting problem is provided. Didactic lectures and group and individual therapy, in combination with the individualized treatment needs of the client, are provided. Aftercare planning and referral services are provided.

MEDICAL DETOXIFICATION

The systematic reduction of the amount of a drug in the body or the elimination of a drug from the body concomitant with supportive treatment service.

OUTPATIENT

Scheduled, periodic care, including diagnosis and therapy, in a nonresidential setting. Correctional institutions are considered nonresidential.

OUTREACH

Activities within a community for early case finding and early intervention services to drug and alcohol abusers. These activities would also include efforts to educate various groups about drug and alcohol abuse.

PROGRAM DIRECTOR

An individual who is appointed by the governing authority of a program or the authorized agent to act on its behalf in the overall management of the program.

RECOVERY

An ongoing process that involves the absence of mood altering chemicals, and an ongoing management of obsessive thinking, self-destructive obsessive and compulsive behavior, and the reduction of psychosocial harm to the self and others.

RESIDENTIAL CARE

Substance abuse services that are provided in a live-in setting. Such services may be supplemented with diagnostic services, counseling, vocational rehabilitation, work therapy, or other services that are judged to be valuable to clients in a treatment or rehabilitative setting.

SCREENING

A general examination of a potential substance abusing or chemically dependent individual to determine the need for treatment services and further assessment.

SCREENING, ASSESSMENT, REFERRAL, AND FOLLOW-UP (SARF)

The performance of a variety of clinically and culturally appropriate examinations necessary to determine specific service needs of the client and assist the client in receiving those services through (1) referral and follow-up, (2) case management, or (3) both.

STAFF

An individual who works in a licensed substance abuse program.

STUDENT ASSISTANCE PROGRAM (SAP)

Activities to provide a prevention and intervention mechanism for addressing high risk substance abuse behaviors in adolescents.

STUDENT FAMILY PROGRAM (SFP)

A comprehensive program delivered by or under the authority of a school system that provides education, identification, screening, referral and support for youth/families affected by their own or others' substance abuse problems, as its sole focus or as a component of its services.

SUBSTANCE

The misuse of a chemical, including alcohol, tobacco and other drugs, that, upon entering a human body, alters the mood or level of consciousness.

SUBSTANCE ABUSE

The act of abusing alcohol, tobacco or other drugs. The individual retains the "power of choice" and can choose to violate his/her own personal values and use to excess.

SUBSTANCE ABUSE PROGRAM

A public or private firm, association, organization or group offering substance abuse treatment, rehabilitation, case finding or prevention services.

VOLUNTEER

An individual who provides a service of his own free will. The Michigan Center for Substance Abuse Services has a service network consisting of 30,000 to 40,000 volunteers.

appendices

A Summary of Survey of Adolescent Materials Collected in United States

B Michigan Synthetic Estimates

C Primary Drug by Age Groups for Youth under 21

D Michigan Adolescent Services Summary

E Metropolitan Court Judges Committee Report 1987

F Organization of the Tobacco-Free Teens Program—American Lung Association

G Recommended Additions to Administrative (Licensing) Rules

Appendix A

Summary of Survey of Adolescent Materials Collected in United States, June 4, 1992

	Are any state level groups now meeting or have any met to discuss adolescent services?	Do you have any special licensing rules for adolescent services?	Do you have any special contractual requirements for programs providing adolescent services?
Alaska			
Arkansas	x		
California		x	
Colorado	x	x	x
Connecticut	x		
Florida	x		
Georgia	x	x	x
Idaho	x	x	x
Indiana	x		
Illinois	x		
Iowa	x	x	x
Kansas	x	x	
Kentucky			
Maine	x		
Massachusetts	x	x	x
Minnesota		x	x
Mississippi			
Missouri	x		x
Montana			
Nevada	x		
New Hampshire	x		
New Jersey	x		
New York		x	x
Oklahoma	x	x	
Pennsylvania	x		
Puerto Rico	x		
Rhode Island		x	
South Dakota	x		
Tennessee	x		x
Texas	x	x	
Utah	x	x	x
Virginia	x		
Washington	x		x
Washington, D.C.			
West Virginia	x		
Wisconsin	x	x	x
Wyoming	x		

x = yes

Michigan Synthetic Estimates

Estimate of Alcohol and Illicit Drug Use Among Adolescents of 12-17 Years of Age
Michigan, 1991

Drugs	Lifetime	Past Year	Past Month
Any Illicit Drug	224,932 (29%)	149,998 (19%)	83,645 (11%)
Alcohol: ever used	605,182 (77%)	509,909 (65%)	302,959 (38%)
Alcohol: been drunk	349,272 (44%)	271,237 (34%)	144,773 (18%)

Source: National Institute on Drug Abuse, 1990 and 1991 National High School Survey and 1990 Census.
MDPH/CSAS/EDS 9/92

The Center for Substance Abuse Services estimates that approximately 159,893 Michigan adolescents age 12-17 are in need of substance abuse treatment (83,645 past month illicit drug users plus 144,773 who have been drunk in the past month times .7).

Past month drug and alcohol abuse figures are used, rather than lifetime or past year figures, on the assumption that these individuals are most likely to accept or seek treatment services.

Approximately 70 percent of substance abusers use both alcohol and other drugs. The Center for Substance Abuse Services estimates factors in this frequency of poly-drug abuse.

Appendix C

Primary Drug by Age Groups for Youth under 21 at Admission, FY 1989/90 (Treatment)

Primary Drug	Age Groups					Total (%)
	Under 13	13-14	15-16	17-18	19-20	
Alcohol	87	598	1,479	1,460	2,027	5,651 (58)
Heroin				3	11	14 (<1)
Cocaine	1	6	36	107	271	421 (4)
Crack Cocaine	1	5	17	69	255	347 (4)
Marijuana/Hashish	21	183	616	508	518	1,846 (19)
Other	14	53	62	47	49	225 (2)
None/Sig Oth Subs Abuse	433	302	204	178	140	1,257 (13)
Total	**557**	**1,147**	**2,414**	**2,372**	**3,271**	**9,761* (100)**

* Excluded were admissions for which either of data items was missing.

Primary Drug by Age Groups for Youth under 21 at Admission, FY 1990/91 (Treatment)

Primary Drug	Age Groups					Total (%)
	Under 13	13-14	15-16	17-18	19-20	
Alcohol	78	531	1,420	1,836	2,229	6,094 (63)
Heroin	3		1		7	11 (1)
Cocaine	2		14	33	129	178 (2)
Crack Cocaine	12	3	16	61	264	356 (4)
Marijuana/Hashish	8	65	325	430	454	1,282 (13)
Other	9	35	56	39	43	182 (2)
None/Sig Oth Subs Abuse	660	344	340	195	93	1,632 (17)
Total	**772**	**978**	**2,172**	**2,594**	**3,219**	**9,735* (100)**

* Excluded were admissions for which either of data items was missing.

Primary Drug by Age Groups for Youth under 21 at Admission, FY 1991/92 (Treatment)

Primary Drug	Age Groups					Total (%)
	Under 13	13-14	15-16	17-18	19-20	
Alcohol	100	543	1,359	1,598	1,958	5,558 (60)
Heroin	2		1	2	4	9 (<1)
Cocaine	2		13	31	87	133 (1)
Crack Cocaine	13	7	18	79	197	314 (3)
Marijuana/Hashish	4	62	277	395	440	1,178 (13)
Other	16	36	65	50	51	218 (2)
None/Sig Oth Subs Abuse	948	402	326	170	75	1,921 (21)
Total	1,085	1,050	2,059	2,325	2,812	9,331* (100)

* Excluded were admissions for which either of data items was missing.

MICHIGAN ADOLESCENT SERVICES SUMMARY—AUGUST 1992

Adolescent Services—Inpatient

PROGRAM	CAPACITY	UTILIZATION	WAITING LIST	CA CONTRACT?	UNIT COST
Bay Haven, Bay City	10 beds	45	No	Yes POS**	$295/bed/day $450 Detox bed/day
New Day Center Adventist Hospital, Battle Creek	24 beds	33	No	No	$550-$600/bed/day
Munson Hospital, Traverse City	11 beds	70	Varies	Yes POS 800 bed days=27.5 kids	$380/bed/day
Marquette General, Marquette	8 beds	50	No	Yes POS $130 bed day rate	$200/bed/day

Adolescent Services—Residential

PROGRAM	CAPACITY	UTILIZATION	WAITING LIST	CA CONTRACT?	UNIT COST
Maplegrove, West Bloomfield	14 beds 6-8 clients/day treatment	85	No	POS 200 bed days	$325-$350/bed/day
Ardmore Center, Livonia	25 beds 15 clients/day treatment	50	No	No	Unavailable
Brighton Hospital, Brighton	20 beds	40	No	POS	$405/bed/day
Alpha House, Ann Arbor	16 beds	100 except summer	4-5 (6 weeks)	POS $50/bed/day $95,000 ceiling	$131/bed/day
Shiloh Family, Marquette	11 beds	98-100 for past 18 months	5	POS	$125/bed/day

Lake Drive Recovery, Grand Rapids	9 beds	100 for past year	2	No	$124/bed/day
Dakotah Family, Grand Rapids (Claim 70% recovery rate, 10-14 day stay)	**12 beds**	**85 Expanded from 9 to 12 beds**	**No**	**Yes POS $255,000**	**$235/bed/day**
Shiloh Family, Grand Rapids	15 beds	90	4 to 10	Yes POS $147,000	$110/bed/day
Ojibway Group Home, Mt. Pleasant	**5 beds**	**50**	**No**	**No**	**$95/bed/day**
Alternatives for Girls, Detroit	4 beds	50	No	Yes POS 90 beds	$82/bed/day

Adolescent Services—Intensive Outpatient

Seaway Hospital, Trenton	10 plus family	50	No	No	$1800-$2000 4 weeks, 3 days/week
North Ottawa Hospital, Grand Haven	**10**	**85 to 90**	**No**	**Yes POS $50,000**	**$162 per day $95 for CA clients with 20 visit maximum**
Gateway, Kalamazoo	20 (8 hour days)	50	No	Yes POS	$150 per day $95 2 to 5 p.m. after school $30/hour aftercare
Straight, Plymouth	**65**	**80 to 90**	**No**	**No**	**$13,850 16 to 20 months**
Insight, Flint	7 to 15	Varies	No	No	$85 per day
CCDA/Livonia Counseling Center, Livonia	**10**	**80**	**No**	**Yes POS $800,000**	

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Adolescent Services—Outpatient

CCDA/Livonia Counseling Center, Livonia	50 to 75	100		Yes POS All ages	$55/hr. individual
Growth Works, Plymouth	**20 groups (2 hrs./2 therapists) 10 indiv.**	**80**	**No**	**No**	**$70 individual $45 group**
Brighton Hospital, Brighton	No limit	N/A	No	No	$75 individual/family $50 group
Children's Center, Detroit	**No limit**	**125 youth/year at risk NOT users**	**No**	**Yes POS $140,000**	**$55 individual/family $16 group**
McAuley, Ann Arbor	20	85	No	No	$80 individual $60 group $20 aftercare
Chem Dep Res., Battle Creek	**12 to 15 grp, 4 days/wk. indiv.once/ wk.**	**50**	**No**	**No**	**$80 individual $40 group**
Gateway, East Lansing	500 youth per year	50	No	Yes POS 1,750 hours	$55 individual $16 group/family
Ren West, Detroit	**75 to 85**	**90**	**No**	**Yes POS 696 hrs., 58 drug screens, 1369 hrs. group**	**$55 individual $36 group**
Family Services, Detroit (3 sites)	8,760 hrs./year	608 hrs./year	No	Yes POS $33,419	$55 individual/family $16 group
New Visions, Marquette	**100 clients per year**	**100**	**2 week maximum**	**Yes POS**	**$55 individual**

PROGRAM	CAPACITY	UTILIZATION	MEDICAL UNIT	DJ CONTRACT	RATE
Dakotah Family, Grand Rapids	120	100	No	No	$76 individual $22 group
Gateway Juvenile, Kalamazoo (Does assessments for youth in detention. This is a unique program in Michigan.)	**45**	**50**	**No**	**Yes Staffing grant**	**$150 day $95 after school $35 aftercare**
Henry Ford Health System, Maplegrove West Bloomfield	50 to 75	N/A	No	No	$96 individual
Maplegrove Grosse Pointe	**20+**	**N/A**	**No**	**No**	**$46 group**
Maplegrove Dearborn	20+	N/A	No	No	
Wyandotte Health Clinic, Wyandotte	**20+**	**N/A**	**No**	**No**	**$90 individual $50 group sliding fee scale**

* Coordinating agencies for MDPH CSAS
**Purchase of Service Fixed Unit Rate

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Appendix E

Metropolitan Court Judges Committee Report 1987

The following is a list of recommendations for courts developed at the Juvenile and Family Substance Abuse 1987 working conference.

• Courts must intervene early to increase the effectiveness of substance abuse treatment.

• Treatment and services for juvenile and family substance abuse must focus on the family.

• Courts must hold children and their families accountable for substance abuse and mandate sanctions and remedies, not withstanding the fact that dependence on substances is widely regarded as a disease.

• Courts must support and enforce parental responsibility for their children's abuse of substances.

• Courts must issue and enforce orders for protection, treatment and rehabilitation of children, family members or other household members whose substance abuse detrimentally affects the child.

• Courts must have authority to place juvenile offenders in a secure treatment facility, when necessary, to assure control and treatment if substance abuse is determined to be a significant threat to the safety of the child or others.

• Juvenile courts should have jurisdiction over juveniles who drive while under the influence of substances.

• Juvenile courts should be given authority to suspend, revoke or delay access to a driver's license for juveniles who have been determined to abuse substances.

• Courts should strictly enforce laws prohibiting parents and others from providing proscribed substances to children.

• When substance abuse is a significant contributing factor in domestic relations and civil or criminal family violence cases, courts must impose sanctions and require treatment.

Assessment and Treatment Recommendations

• A full range of substance abuse assessment and treatment programs should be funded and made readily available to the courts.

• Courts must develop a process for screening, assessing and monitoring the presence of substance abuse by a child or family.

• All judges and intake, probation and casework staff must have substance abuse training.

• Interdisciplinary approaches must be used for treatment and rehabilitation.

• Treatment plans should require that providers submit progress reports to the court for monitoring and enforcement purposes.

• All correctional facilities, state training schools and community-based alternative programs should provide substance abuse treatment and habilitation to meet the needs of juveniles and families.

The youth gang large-scale criminal drug trafficking phenomenon has exploded recently to the extent that our judicial system has not developed an adequate response. Based on this information, the following recommendations were made:

• Communities should use various strategies, including aggressive suppression, to address drug trafficking by youth gangs.

• Parents must be informed about youth gang substance abuse activities and assume responsibility for preventing their children from becoming criminally involved through gang association.

• All judges and intake, probation and casework staff must be trained in the involvement of organized youth gang drug activities.

• Juvenile offenders should be screened and assessed for their possible involvement with gang drug trafficking activities.

• Courts should consider waiver to adult jurisdiction for those youth charged with serious gang-related drug trafficking.

• Federal and state legislation should make serious juvenile youth gang drug trafficking an interstate criminal activity.

Appendix F

Organization of the Tobacco-Free Teens Program—American Lung Association

Purpose

1. The Tobacco-Free Teens Program is designed to assist young people in quitting tobacco use before it becomes a long-term addiction. The success of this program lies within each individual and his/her personal motivation to work to change his/her behavior.

2. The Tobacco-Free Teens Program is only for teens who have the desire to quit. It is suggested that your school or organization adopt a smoking education program as an alternative to suspension rather than use Tobacco-Free Teens as a disciplinary action for possessing or using tobacco products on the school campus. The program needs to be seen as a privilege, not as a punishment.

3. Teenage smokers will often be using alcohol or other drugs that trigger their use of tobacco. If other drug issues arise and seem to overshadow the tobacco issues, participants need to be reminded that the focus of this program is tobacco cessation. The principles for stopping tobacco use are applicable to cessation of other drugs. You may wish to tactfully refer students to a counselor if other drug issues continue to arise.

Time Commitment

1. Tobacco-Free Teens is an eight-session program that extends over a four-week period of time.

2. Class sessions last approximately 50 minutes.

3. It is recommended that the program be held during the normal school day. Consider varying the times each session is offered so that a student won't be absent consistently from any specific class. If students are part of a work-study program, consider offering the program during the morning only.

4. It is important that the students receive approval from their teachers if the program conflicts with their regular schedule.

5. The faculty needs to be briefed about the program at a staff meeting before the students seek their support.

Tobacco-Free Teens Program Objectives

1. Participants will demonstrate increased motivation to quit using tobacco by exhibiting
   a. increased knowledge of the benefits of quitting and
   b. increased intention to quit.

2. Participants will demonstrate increased skills for quitting by exhibiting
   a. increased understanding of their tobacco habit,
   b. increased understanding of nicotine addiction,
   c. increased ability to identify coping strategies, and
   d. increased ability to use coping strategies.

3. Participants will increase the likelihood of not using tobacco permanently by exhibiting
   a. decrease in tobacco use,
   b. at least one voluntary quit attempt,
   c. increased duration of voluntary quit attempt, and
   d. the ability to stay off tobacco for at least one year.

4. Participants will increase the likelihood of using positive health habits in place of tobacco use by exhibiting
   a. increased knowledge of the benefits of exercise and proper nutrition and snack choices and
   b. increased ability to implement stress management techniques.

Recommended Additions to Administrative (Licensing) Rules

The Adolescent Study Group recommends that the following requirements apply to programs serving adolescents:

The program must adopt a treatment protocol that details its approach to the treatment of adolescents and demonstrates that the program can provide appropriate services to adolescent clients.

The program must obtain parental or legal guardian authorization at the time of admission to provide emergency medical, dental and surgical care.

The program must document attempts to obtain the active participation of the adolescent's family or family surrogate in the treatment process.

The program must establish guidelines for admission and treatment when parental consent cannot be obtained. The program must document in case records their attempts to meet the adolescent's needs if parental involvement for 14- to 17-year-olds cannot be secured for admission and/or if the parents will not participate in the treatment process.

The case record and continuing care plan must contain evidence of an assessment of the appropriateness of the adolescent's home setting.

The program must use administrative and clinical admission criteria which accurately reflect widely accepted admission protocols.

The program must have written policies and procedures to ensure 24-hour accessibility to crisis intervention services.

The program must maintain a list of program staff and acceptable ratios of program staff to clients. These ratios must be reviewed and updated on an annual basis.

The program must employ case managers, primary counselors and family counselors who have knowledge of adolescent chemical dependency etiology and dynamics, adolescent development, family systems, behavior management and self-help groups, and who have direct counseling experience.

The program must use assessment and diagnostic instruments appropriate for the types of adolescent clients the program is designed to serve.

The program must provide in-service training of direct service program staff in areas specific to the treatment of chemically dependent adolescents, including training on addiction and treatment, relapse prevention, family dynamics, domestic aggression, growth and development, sexual abuse, sexuality, sexually transmitted diseases, HIV/AIDS, mental health issues (including depression, anxiety and other disorders), independent living skills, habilitation vs. rehabilitation, experimentation and decision making, cultural competence, recreational activities, child and adolescent management techniques, appropriate discipline, crisis intervention, interpersonal communication, and proper and safe methods of restraint and first aid.

The program shall assure that staff receive a minimum of 50 hours of training in their first year of employment and 25 hours of training on an annual basis thereafter.

Program components to be provided on site or through the referral process shall minimally consist of the following:

1. Noninstitutional homelike environment
2. Adolescent-only groups (except with documented clinical rationale for incorporating adolescents into adult groups)
3. Educational services
4. Health screening, testing and health information on HIV/AIDS, STDs and TB with cooperative agreements as needed to secure services
5. Recreational services (active and quiet)
6. Family services and/or treatment
7. Aftercare
8. Self-help groups
9. Chemical dependency and related information including tobacco related products
10. Spiritual services
11. Vocational services as needed
12. Nutritional services
13. Psychological/psychiatric services

14. Individual, group and family therapy
15. Didactics
16. Independent living skills
17. Parenting instruction

The program must have written policies and procedures for facilitating a face-to-face contact between the client and a physician, physician's assistant or a nurse practitioner within 30 days of admission. The results of the contact must be maintained in the case record.

The program must have a policy to promote access to appropriate educational services for each adolescent when the treatment intervention necessitates a significant absence from school. Monthly progress reports from the provider of the educational services will become part of the treatment record.

The program must assure that an educational capability assessment will be conducted or facilitated that includes literacy, vision and hearing testing. The results of the testing shall become part of the treatment record and any deficits found in the course of this assessment shall be addressed by the program directly or through referral.

The program must conduct treatment and discharge planning in coordination with the staff of the client's ongoing educational setting. With the client's consent, the program shall assist in identifying to responsible educational facilities, the client's need for special learning, behavior problems, teachers, tutors, classroom teaching, vocational education needs and or other needs, as appropriate.

The program must provide treatment experiences, literature and lectures that are easily understood by, and appropriate for, the comprehension levels of adolescents served.

The program must complete a discharge plan that includes a continuing treatment plan with provisions unique to adolescents to include leisure time, education, relapse prevention, specialized adolescent services and role of family or surrogate. The plan must be developed cooperatively by the client, program staff, referring agency, family (or surrogate) and the anticipated provider of aftercare services (when appropriate). The plan must be signed by the client.

The Adolescent Study Group recommends that the following additional requirements apply to residential programs serving adolescents:

The health assessment shall include the adolescent's immunization status and, if not current with requirements from the Michigan Department of Public Health, the program shall document and make reasonable attempts to secure needed immunizations.

Programming shall be structured and cover a minimum of eight hours per day, seven days per week, of planned therapeutic and recreational activities.

A minimum of ten hours of educational services per week shall be provided by direct contact with a certified teacher.

The program shall maintain a ratio of not less than one primary therapist to every six adolescents and a ratio of not less than one family therapist to every ten clients.

The program must provide a recreational rehabilitation program to clients. Activities must be planned to develop constructive leisure time activity skills and must be documented in each individualized treatment plan.

The Adolescent Study Group recommends that the following additions/modifications apply to all treatment programs:

Documentation of health assessments shall be available that verifies that each employee and volunteer who has contact with a client four or more hours per week for more than two consecutive weeks is free from communicable tuberculosis. Freedom from communicable tuberculosis shall be verified at the time of employment and on an annual basis thereafter.

Document assessment of each family member's (including siblings) chemical use history and risk status and facilitate referrals for services as needed.

A minimum of 40 hours of training shall be provided to staff in their first year of employment and 20 hours on an annual basis thereafter.

Program shall demonstrate and implement a plan for assuring continued clinical competence to include as a minimum:

a. annual clinical performance assessments
b. annual peer reviews for each area
c. applicable quality improvement reports

The program shall demonstrate and implement a plan for assuring continued client input in relation to program functions. This information shall be compiled and available for review on an annual basis.

Modifications for Part I. General Provisions

Physical facilities

• The governing authority shall assure that each program has physical facilities and equipment adequate for each specific type of service and or special population serviced.

Job descriptions

• Each program shall have written job descriptions that are specific to the populations being served for each position.

Personnel record requirements

• The staff member's personnel file shall contain the staff member's verification of current credentials.

• Evidence of a criminal justice background check shall be in the personnel record of all persons having contact with children/adolescents.

The Adolescent Study group recommends that the following general provisions apply to Student/Family Programs:

The Student/Family Program (SFP) has a written policy on substance abuse problems addressed by the program including its philosophy, organizational structure and description of service components.

The policy is signed by the chief administrative officer of the school district.

The policy states that substance abuse problems among youth and their families are responsive to intervention, treatment and habilitation/rehabilitation.

The policy describes the responsibilities and limits of the school and its staff.

The policy states that participation in the SFP will not affect future participation or other opportunities in school programs, nor will participation protect the student from disciplinary action for continued violations of school rules and policies.

There are written rules governing how SFP records are to be maintained that protect the identity of the student, facilitate case management, support and follow-up, provide access to statistical information for program evaluation and specify:

1. Length of time records are kept;
2. Who has access to records;
3. What information is to be released, to whom, and under what conditions; and,
4. What use, if any, records may be used for purposes of research or evaluation.

Records maintained by the SFP shall not become part of a student's school record.

Federal regulations on confidentiality of alcohol and drug abuse records are adhered to.

There are written procedures for referrals to the SFP by (1) school staff and (2) voluntary referrals from students or family members.

Procedures for referrals include, but are not limited to:

1. Preliminary assessment by the school's core team and/or SFP coordinator;
2. Diagnostic evaluation by a qualified professional if needed;
3. Referral to treatment or other appropriate assistance; and
4. Re-entry, follow-up and ongoing support services.

There are procedures for notifying parents of all students participating in the SFP of their child's involvement.

1. Parents are informed immediately when their child has violated school policy.
2. Parents are informed as soon as practicable when their child is self-referred or referred by other means. SFP staff document reasons for any decision to postpone parent notification and involvement.

The organization and operation of the SFP involves

the school principal and other appropriate senior school staff.

The physical location of the SFP facilitates easy access while assuring confidentiality.

The SFP initiates and maintains cooperative referral arrangements with a range of treatment providers and providers of other services that may be needed by youth referred to the program.

SFP staff have appropriate qualifications including, but not limited to:

1. Experience and expertise in dealing with substance abuse problems;
2. Skill in screening, interviewing, motivating and referring;
3. Knowledge of adolescent developmental issues and family dynamics; and,
4. Appropriate administrative experience.

references

Bryce, M. E. & Lloyd, J. C. (EDs). (1980). Treating families in the home: an alternative to placement. Springfield, Il: Charles C. Thomas.

Byalin, Smith, Chatkin, & Wilmot. (1987). Bridge over troubled waters: an innovative day-treatment program for older adolescents. *International Journal of Partial Hospitalization. 4*(3), 217-226.

Catalano, R. F., Hawkins, J. D., Wells, E. A., Miller, J. & Brewer, D. (1990-1991). Evaluation of the effectiveness of adolescent drug abuse treatment, assessment of risk for relapse, and promising approaches for relapse prevention. *International Journal of the Addictions. 25*(9A & 10A), 1085-1140.

Chaney, S. E. & Piercy, F. P. (1988). A feminist family therapist behavior checklist. *The American Journal of Family Therapy. 16*, 305-318.

Chavez, E. L., Edwards, R. C., & Oetting, E. R. (1989, Nov.-Dec.). Mexican American and White American school dropouts' drug use, health status, and involvement in violence. *Public Health Reports. 104*(6), 594-604.

Conroy, C. W. (1988, May). The many facets of adolescent drinking. *Bulletin of the Menninger Clinic*. 229-244.

Covington, S. S. (1982, April). Sex and violence--the unmentionables in alcoholism treatment. Paper presented at the National Alcoholism Forum of the National Council on Alcoholism, Washington, D.C.

De Leon, G. & Deitch, D. (1985). Treatment of the adolescent abuser in a therapeutic community. In A. Friedman & G. Beschner (Eds.). Treatment services for adolescent drug abusers. (DHHS Pub. No. (ADM) 85-1342). Rockville, MD: National Institute on Drug Abuse.

Duda, F. C. (1980). Peer influence as a possible referral source for substance abuse treatment. *Military Medicine. 145*, 829-830.

Ensminger, M. E., Brown, C. H. & Kellam, S. G. (1982). Sex differences in antecedents of substance use among adolescents. *Journal of Social Issues. 38*(2), 25-42.

Friedman, A. S. & Glickman, N. W. (1986). Program characteristics for successful treatment of adolescent drug abuse. *The Journal of Nervous And Mental Disease*. 669-679.

Furst, C. J., Beckman, L. J., Nakamura, C. Y. & Weiss, M. (1981). *Utilization of alcoholism treatment services*. Report prepared for the State of California Department of Alcohol and Drug Programs, UCLA Alcohol Research Center, Los Angeles, CA.

Gillis, H. L. & Simpson, C. (1991, October). Project choices: adventure-based residential drug treatment for court-referred youth. *Journal Of Addictions And Offender Counseling. 12*, 12-27.

Glassner, B., Carpenter, C. & Berg, B. (1986). Marijuana in lives of adolescents. In G. Beschner & A. S. Friedman (Eds.). *Teen drug abuse.* (pp.105-123). Lexington, MA: Lexington Books.

Golden, L. & Schwartz Klein, M. (1987). Treatment as a habilitative process in adolescent development and chemical dependency. *Alcoholism Treatment Quarterly.* 4(4), 35-41.

Greenhouse, C. (1992, July/August). Case management may be the wave of the future for drug abuse treatment. *NIDA Notes.*

Hernandez, J. T. (1992, Dec). Substance abuse among sexually abused adolescents and their families. *Journal of Adolescent Health. 13*(8), 658-62.

Hoffman, N. G. (1991, Dec/Jan). Adolescent treatment success rates soar when key elements are present. *Adolescent Counselor.* 19-25.

James, B. & Nasjleti, M. (1983). Treating sexually abused children and their families. Palo Alto, CA: *Consulting Psychologist Press.*

Johnson, P.J., & Rubin, A. (1983). Case management in mental health: A social work domain? *Social Work,* 28, 49-55.

Johnston, L. (1993, April 8). News and Information Services. The University of Michigan.

Johnston, L. (1993, April 9). News and Information Services. The University of Michigan.

Johnston, L. (1993, April 13). News and Information Services. The University of Michigan.

Lopez, J. M. O., Redondo, L. M. & Martin, A. L. (1989). Influence of family peer group on the use of drugs by adolescents. *The International Journal of the Addictions. 24*(11), 1065-1082.

Mensch, B.S. & Kandel, D.B. (1981, April). Dropping Out Of High School and Drug Involvement. *Sociology of Education.* 61, 95-113.

National Council of Juvenile and Family Court Judges. (1988). *Drug - the American family in crisis: a judicial response, 39 recommendations.* Metropolitan Court Judges Committee Report. 1-51.

Nichols, M. (1985). Theoretical concerns in the clinical treatment of substance-abusing women: a feminist analysis. *Alcoholism Treatment Quarterly. 2,* 79-90.

The North Carolina Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. (1987, March). The North Carolina youth substance abuse plan. 1-28.

Peninsula Village Program Description and Treatment Philosophy. Penninsula Village, Louisville, Tennessee.

Selekman, M. (1991, March). "With a little help from my friends": the use of peers in the family therapy of adolescent substance abusers. *Family Dynamics Of Addiction Quarterly*. 1(1), 69-76.

Shoemaker, R. H. & Sherry, P. (1991). Posttreatment factors influencing outcome of adolescent chemical dependency treatment. *Journal of Adolescent Chemical Dependency*. 2(1), 89-106.

Singer, M. I., Petchers M. K. & Hussey D. (1989). The relationship between sexual abuse and substance abuse among psychiatrically hospitalized adolescents. *Child Abuse & Neglect*. 13(3), 319-25.

Todd, T. T. (1991). The evolution of family therapy approaches to substance abuse: personal reflections and thoughts on integration. *Contemporary Family Therapy*. 13(5), 471-495.

Toray, T., Coughlin, C., Vuchinich, S. & Patricelli, P. (1991, July). Gender differences associated with adolescent substance abuse: comparisons and implications for treatment. *Family Relations*. 338-344.

Troiden, R. R. (1988, March). Homosexual identity development. *Journal of Adolescent Health Care*. 9(2), 105-113.

U.S. Department of Health and Human Services Public Health Service. (1991). *A Guidebook for Planning Alcohol Prevention Programs with Black Youth*. (DHHS Publication No. (ADM) 81-1055).

U.S. Department of Health and Human Services Public Health Service. (1991). *Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems*. (DHHS Publication No. (ADM) 91-1744). Washington, DC: U.S. Government Printing Office. 1-29.

U.S. Department of Health and Human Services Public Health Service. (1991). *Drug Use Among High School Seniors, College Students and Young Adults, 1975-1990*. (DHHS Publication No. (ADM) 91-1813).

U.S. Department of Health and Human Services Public Health Service. (1992). *Empowering Families, Helping Adolescents*. (DHHS Publication No. (ADM) 92-1745). Office for Treatment and Improvement. Rockville, MD.

U.S. Department of Health and Human Services Public Health Service. (1990, September). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. (Conference Edition). 168-186, 571-578.

U.S. Department of Health and Human Services Public Health Service. (1991). *The Adolescent Assessment/Referral System*. (DHHS Publication No. (ADM) 91-1735).

U.S. Department of Health and Human Services Public Health Service, Preliminary Estimates From the 1992 National Household Survey on Drug Abuse, Advance Report Number 3, June 1993.

U.S. Department of Labor. (1991, October). *What Works: Workplaces Without Alcohol and Other Drugs*. U.S. Government Printing Office: 282-144/54629. 1-66.

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